DOCUMENT RESUME

ED 319 199 EC 230 888

AUTHOR Hill, Bradley K.; And Others
TITLE Living in the Community: A Comparative Study of Foster Homes and Small Group Homes for People with Mental Retardation. Project Report 28.
INSTITUTION Minnesota Univ., Minneapolis. Center for Residential and Community Services.
SPONS AGENCY Administration on Developmental Disabilities (DHHS), Washington, D.C.
PUB DATE Dec 89
GRANT 90DD0051; 90DD0145
NOTE 215p.
AVAILABLE FROM Center for Residential and Community Services, Institute on Community Integration, University of Minnesota, 207 Pattee Hall, 150 Pillsbury Dr., S.E., Minneapolis, MN 55455 ($15.00).
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC09 Plus Postage.
DESCRIPTORS *Adult Foster Care; Adults; Attitudes; Community Programs; Demography; *Developmental Disabilities; *Group Homes; *Mental Retardation; National Surveys; Normalization (Handicapped); Quality of Life; Residential Care; Social Integration

ABSTRACT

The study surveyed 181 specialized foster care homes or small (with 6 or fewer residents) group homes providing residential care for persons (N=336) with mental retardation and related developmental disabilities. The study found that the community residential facility sample was generally much less well integrated into the life of the community than was a sample of the general population. Differences were greatest in the areas of vocational/educational integration and social integration. Differences were least and actually favored the sample of persons with mental retardation in community residential facilities in the area of leisure/recreational integration. The study also found that many residents, even those with severe impairments, are functioning well in small living arrangements in normal communities. High rates of satisfaction and relatively positive community and neighborhood acceptance were reported. Specific results are reported in chapters on: facility and care provider characteristics (e.g., size, operator type, admission requirements, licensing and monitoring, preservice training, salaries); resident characteristics, relationships, and activities (e.g., demographics, level of retardation, health limitations, family contact, leisure activities); program characteristics (e.g., case management, program plans, and specialized services); and integration into the life of the community. Contains about 200 references.

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LIVING IN THE COMMUNITY:

A comparative study of foster homes and small group homes for people with mental retardation

Report #28

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December 1989

The data gathering and analyses in this report were supported by grants from the Administration on Developmental Disabilities (90DD0051 and 90DD0145). The findings and observations contained in this report do not necessarily reflect the position of the Administration on Developmental Disabilities.

The recommended citation for the publication is:

Hill, B.K., Lakin, K.C., Bruininks, R.H., Amado, A.N., Anderson, D.J., & Copher, J.I. (1989). *Living in the community: A comparative study of foster homes and small group homes for people with mental retardation* (Report No. 28). Minneapolis: University of Minnesota, Center for Residential and Community Services.

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Acknowledgements

This report represents the combined efforts of many people. In addition to the individuals who are listed as authors, a large number of people contributed to the completion of this report.

We are very grateful to Connie McAlear and Judy Moore of the Administration on Developmental Disabilities for their support in completing this study. We also greatly appreciate the assistance of Jim Intagliata in the instrumentation of this study. We benefited considerably from his experience in this area.

Carolyn White and Matt Matteson played key roles in this project. Cheryl Morgan prepared the text, tables, and graphics for this report. The quality of her work will be easily discerned as the report is reviewed. This work was completed in the midst of other reports and duties that are part of managing a very busy office.

Finally and foremost we must thank our respondents. This study required unusual amounts of time, reflection, and record keeping on the part of respondents. These people graciously participated in a range of telephone interview and mail surveys, as well as telephone follow-up on their responses. They stuck with the study when they must have often wondered whether the product could ever be worth the trouble. We can only hope that with this report they will feel that the value of the undertaking was equal to the required effort.

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EXECUTIVE SUMMARY

This report summarizes the findings of a survey of the most rapidly growing residential care settings for persons with mental retardation and related developmental disabilities, specialized foster care homes, and small group homes of 6 or fewer residents. The data reported were gathered in a two-stage, nationally representative, random sample of 181 homes and 336 of their residents. The study gathered extensive data on the facilities and careproviders, and on the residents, the programs and services they received and their activities and day experiences of life "in the community." The study was organized to collect data by facility type--specialized foster care homes, group homes without ICF-MR certification and ICF-MR certified group homes--and size distinctions (4 and fewer residents and 5 or 6 residents). A brief summary of findings follows.

Characteristics of Facilities (Chapter 3)

- *Size*: Among the "small" facilities (4 or fewer residents) in this study, foster homes averaged 2.2 residents with handicaps, group homes averaged 3.3 and ICF-MR certified group homes averaged 3.9 residents with handicaps. The "large" homes (5 or 6 residents) averaged 5.6, 5.6, and 5.8 residents with handicaps, respectively. There was a clear pattern among foster homes to house fewer persons with mental retardation than their licensed capacity (66% vs. over 90% for larger group homes and ICFs-MR). Within the same size category, foster homes had larger total households (including both handicapped and nonhandicapped residents) than the other program types.

- *Live-in careproviders*: All foster care homes (100%) and approximately 30% of group homes and ICF-MR certified group homes had live-in staff; the remaining facilities relied entirely on shift staff.

- *Operator type*: Group homes and ICFs-MR were predominantly private nonprofit organizations; about 12% were government operated, 10% were for-profit or operated by individuals.

- *Admission requirements*: Although residents with a full range of impairments were living in the community facilities sampled, individual homes sometimes had formal or informal restrictions on admission, most often related to serious problem behaviors (50% of foster homes), children versus adults (70% of group homes), and persons using wheelchairs (30% of all homes). Foster home operators seemed most concerned about restricting admissions of persons with serious behavior problems, mobility impairments, secondary disabilities (sensory, seizures) and those without independent toileting skills. Aside from age restrictions of children, group homes and ICFs-MR appeared somewhat less restrictive on admission criteria. However, these differences were partly attributable to variations in state policy and regulation of programs, as well as to particular concerns related to personal circumstances and preferences of the operators of the homes. The findings on restricted admission criteria suggest further need to examine existing regulations, relatively low reimbursement rates and available training opportunities if states plan to expand the availability of foster home options for persons with developmental disabilities. Clearly, trends for needed services to accommodate individuals with severe disabilities, whether from further deinstitutionalization or expanded placement from families, appear incongruent with these restrictions in admission criteria.

- *Licensing and monitoring*: All facilities were licensed by some agency, the majority (89%) by the state mental retardation/developmental disabilities agency. Most facilities were visited once a year by the licensing agency (76%); 9% had less than annual visits, 15% were visited more than annually. About 90% of all homes were visited at least quarterly by a case manager of one or more residents.

- *Location*: In all facility types, most of the homes were single family dwellings. Almost half of all foster homes were located in rural areas or small towns, compared to about 20% of group homes. About 70% of all facilities were located in neighborhoods of primarily single family homes, with foster homes showing the highest placement rates in such locations. About 14% of all facilities were in neighborhoods of mixed business and residential use.

- *Modifications*: About one-third of homes had been modified to accommodate residents. Modifications were most common in ICFs-MR (41%) and least common in group homes (24%). Most were for the residents in general (87%), not for specific residents.

- *Unsuccessful placements*: Overall, 60% of homes indicated having had at least one resident whose placement had been terminated because of some form of problem. Most of these unsuccessful placements were at least partially related to problem behaviors of residents.

- *Normalization*: Facilities showed considerable evidence of normalization. Most residents' sleeping hours were individualized (69-87% depending on facility type); 58% of residents made their own decisions about what to wear each day; most careproviders (92-100%) engaged in social activities with residents as a family, and most (80-94%) ate meals as a family. Still only 40% of residents decided about room decoration independently, and only a few had selected their own roommates.

- *Reimbursement*: Per diem reimbursements (in 1986) averaged $22 for foster care, compared with $53 for group homes. ICF-MR certified group homes were most costly, averaging $86. Among facilities, foster care homes had the least variability. Among larger group homes (noncertified facilities of 5 or 6 residents), the average rates of the costliest 10% were over 7 times the rates of the least costly 10%. Much of the variation within categories seemed attributable to differences in state reimbursement practices, resident characteristics or perhaps even historical rate setting practices.

Careprovider Characteristics (Chapter 3)

- Over three-fourths of all the homes had a single reimbursement rate for all their residents. Differentials were reported, mostly for reasons of personal care in foster homes. Support was seldom added for persons with behavior problems, despite its association with demission.

- *Age*: Three-fourths of careproviders in group homes and ICFs-MR were 36 years of age or younger compared to only 10% of foster careproviders. The average age of foster careproviders was 53-54 years (48% were 51 years or older), compared with from 31 to 35 years in other facilities.

- *Gender*: Excluding homes in which live-in couples shared the direct care role (70% of foster homes and 14% of other facilities), 75% of careproviders were women.

- *Marital status*: Most (72%) foster careproviders, but only 48% of other careproviders, were married or in a stable marriage-like relationship; 5% of foster care and 38% of other providers had never married.

- *Race/ethnicity*: Race/ethnicity of careproviders was generally proportional to the distribution of race/ethnicity in the nation as a whole. About 78% were white, non-Hispanics, 14% were black, non-Hispanics, 6% were Hispanics, and 2% were Asian-Americans, Native Americans or Pacific Islanders.

- *Education*: Foster careproviders had less education than other careproviders, 54% of the former and 18% of the latter having a high school education or less. Only 14% of foster careproviders and 34% of group home providers were college graduates. About 20% of group home and ICF-MR staff, but only 2% of foster care providers were currently enrolled students. A substantial degree of differences in educational attainment across service types is likely partially related to age differences and associated historical variations in years of formal education.

- *Years experience*: Foster careproviders averaged 13 years of direct care experience compared to 5 years for other careproviders. However, the real difference may be even greater as the sampling method used in the present study (which sought to interview the direct care person who knew the sample member best) may have biased the findings to careproviders with more extensive experience in group homes and ICFs-MR.

- *Recruitment*: Careproviders were most commonly recruited by other careproviders (38%), followed by provider initiated contact and advertisements (20%). The primary motivation for employment appeared related to personal attraction to the work rather than financial considerations. These reasons seemed unrelated to previous experience involving persons with mental retardation.

- *Prior experience and training*: Between 40% and 60% of staff depending on the facility type had prior experience with persons with mental retardation, depending on the facility type.

- *Preservice training*: Small foster care providers were least likely to have been required to have preservice training (54% vs. 72-89% of other providers). A minority of careproviders, between 26% and 47%, depending on facility type, had taken courses on mental retardation or on working with people with handicaps as part of their general education prior to employment. The amount of preservice training ranged from about 56 to 88 hours.

- *Inservice training*: Most careproviders in small group homes and in ICFs-MR were required to receive inservice training annually (81%), but only 43% of foster careproviders and large group home providers were so required. In the previous year, foster careproviders had received an average 15-18 hours, and other careproviders 28-35 hours of elective and required training.

- *Training adequacy*: The majority of direct care personnel (about 60%) considered their training to have been adequate and appropriate, but about a quarter felt they could use more training. About 12% indicated that training was not sufficiently available. One-third of careproviders were not interested in further training.

- *Expected length of stay*: Overall, 10% of careproviders estimated they would continue in their present role one year or less, and another 13% indicated 2-3 years. Foster careproviders expected to continue considerably longer than other careproviders, despite their more advanced age. Most of the reasons mentioned for working related to areas of personal and/or altruistic commitments.

- *Decision to stay*: Foster careproviders were most likely to mention age, health or retirement as a factor in their decision to stay or leave their job (36% vs. 0-6% of those of other types of facility). In contrast, dissatisfaction with the job, hours, salary, and/or administration was more often mentioned by staff in larger group homes and larger ICFs-MR as a factor affecting decisions to leave (20-31% vs. 5% for foster parents), as was lack of career advancement opportunities (13-25%

depending on group facility type vs. 5% of foster careproviders). Respondents anticipating briefer stays were more highly educated, and were less likely to indicate that they felt they were treated as important and equal members of the resident's team.

- *Salaries*: Excluding foster care, current hourly wages (1986) ranged from $5.40 to $9.60, with no statistically significant differences among large and small or certified and non-certified group homes.

- *Staff ratios and activities*: Staff ratios varied from 2.3 to 3.4 residents per staff member in group homes and ICFs-MR, with larger homes having higher ratios. There was an average of about 5 different persons per week who assumed responsibility for residents of group homes and an average of about 8 in ICFs-MR. Almost all direct care staff in group homes and ICFs-MR prepared meals (96-100% depending on the facility type), most did the laundry (82-87%), a majority did maintenance work (47-76%), most attended program planning meetings (80-94%), many set up program plans or meetings (53-67%), wrote program plans (40-68%) or supervised other staff and scheduled shifts (40-72%).

- *Staffing characteristics and problems*: Few group residences had live-in house parents. A large number of foster homes had one houseparent with a day job in special education (31-42%). About half (51%) of group homes and ICFs-MR reported medium or high rates of turnover (19% reported high); the majority of respondents noted problems finding new staff (70%).

- *Professional staff support services*: All ICF-MR respondents reported visits from nurses, as compared to 25% of the other facilities. The average number of annual nursing visits per resident was 2.7 for foster care facilities, 12.7 for group homes, and 14.9 for ICFs-MR. Speech therapists rarely visited foster homes (only 2% were visited over a one year period). Speech therapist visits were made to 13% of group homes and 45% of ICFs-MR over a one year period. Physical therapists rarely visited facilities other than ICFs-MR (32% of ICFs-MR and 5% of others). Psychologists were most likely to visit ICFs-MR (68% vs. 18% of others). Behavior specialists visited ICFs-MR and group homes more frequently than foster homes (3%). Foster homes generally received fewer home visits from specialists than other facility types.

- *Volunteers*: Volunteers were not commonly used in the surveyed facilities. They were, however, more common in the large facilities (40% of facilities had at least one volunteer) than in the small facilities (12% had at least one volunteer). The average number of residents in these facilities would account for only about half the difference.

Resident Characteristics (Chapter 4)

- *Demographics*: Within the total sample, 77% of sample members were adults, and 11% were children 0-14; foster homes had greater proportions of children and residents 63 years or older. The distribution of gender and ethnic status approximated the U.S. census across all facility types.

- *Mobility*: Most residents could walk well (70-80% depending on facility type) or with some help (10-20%). Nonambulatory residents comprised 12% of foster home, 4% of group home and 7.5% of ICF-MR populations. All residents reported to be "confined to bed" were children aged 5 months to 14 years with severe handicapping conditions.

- *Level of retardation*: About 41% of all residents had severe or profound mental retardation. ICF-MR residents tended to be more intellectually handicapped than other residents (55-60% of the former and 32-37% of the latter were severely or profoundly mentally retarded).

- *Sensory disabilities*: The percentage of persons with severe vision or hearing problems was low, generally less than 10 percent. There were no major differences across facility types.

- *Changes in maladaptive behavior*: Carepersons reported that more than 50% of all problem behaviors had decreased since the resident first came to the home, and 13% had increased in frequency; increases occurred more often in larger facilities. The most common recommended action was additional staff training (recommended by 6-20% of careproviders depending on the facility).

- *Epilepsy*: About 27% of residents were reported to have epilepsy, with no statistically significant differences among facilities. Almost all individuals with seizure disorders were reported to receive medication for them (91%).

- *Health problems*: About 30% of residents had special medical problems, ranging from 23% of small foster home residents to 40% of small ICF-MR residents. These problems seldom required more than monthly visits to a physician or nurse. Heart or respiratory problems were the most frequent reasons for needing medical care.

- *Health limitations*: Approximately half the number of residents with special health problems had limitations in daily activities because of these problems; "many" limitations because of health problems were noted for 6% of foster home residents, no group home residents, and 3% of ICF-MR residents.

- *Medications*: About 64% of all residents in the sample took one or more prescription medications. About 26% took medications for health problems, ranging from 13% of residents in small foster homes to 43% in small ICFs-MR. Psychotropic medications were given to another 26% of residents, ranging from 33% of group home residents, to 26% of foster home residents, to 14% of ICF-MR residents.

- *Communication skills*: Three fourths of all residents were able to talk, ranging from 56% of large ICF-MR residents to 81% of small group home residents; half of these were reported to be easy to understand, and only 15% were reported to be difficult to understand Between 45% of large foster home residents and 68% of small group home residents were said to understand most of what was said to them.

- *Maladaptive behavior*: The mean maladaptive behavior scores on the *Inventory for Client and Agency Planning* fell within the normal range for all facility types, even though in each of the facility categories, some persons were identified with severe problem behaviors. Small group home residents were reported to have more serious maladaptive behavior than foster home or ICF-MR residents, and large ICF-MR residents had slightly more behavior problems than foster home residents. Those with at least one problem behavior ranged from 46% in large group homes to 90% in small group homes. Withdrawn or inattentive behavior was most common among group home and least common among foster home residents; externalized (aggressive or disruptive) behaviors were similar in prevalence to other behaviors, but very low in frequency and severity for most residents. The relatively low rates and severity of problem behaviors appears due in part to restrictions in admission (see Chapter 3).

- *Adaptive behavior*: Group home residents were most independent in self-help skills as well as community living skills, and foster home residents were least independent. When residents aged

21-63 only were included, foster home and ICF-MR residents were similar in adaptive behavior skills, and were slightly less independent than group home residents. Across facility groups, 50% to 75% of residents were independent in toileting skills, 52% to 79% were independent in eating skills, 41% to 66% were independent in dressing skills, and 37% to 57% were independent in bathing skills. Generally, less than 20% of residents required physical assistance for self-help skills. Rates of independence were lower for community living skills, although many persons (20-30%) use the phone, public transportation or buy groceries with little or no assistance.

- *Placement history*: Nearly half of foster home and small ICF-MR home residents had entered the residential services system by the age of 10 years; less than 20% of group home residents and 26% of large ICF-MR residents had entered residential settings by age 10. Group homes had the lowest placement rate for young children, and the highest rate for persons 40 years of age or older. Foster home residents had been in the current setting much longer in than group home and ICF-MR residents, averaging 10 years in contrast to about 3 years for the others. The most common previous placement was a state institution (40% of foster care, 50% of group home and 65% of ICF-MR residents), with the next most common previous placements with parents or relatives (about 20% for foster, 28% for group and 14% for ICFs-MR). About 24% of foster children came from other foster homes. Two dozen reasons were provided for the current placement, with many of the reasons related to movement toward greater social and physical integration, better service and placement in more home-like settings.

- *Projected future placements*: About two-thirds of respondents indicated that there were no known future plans for the resident to move. This ranged from about 55% of large ICF-MR residents to about 80% of large group home residents. Respondents perceived a high degree of satisfaction on the part of residents with their current placements (80%), but about 20% to 40% depending on facility type indicated that residents could eventually move to more independent placements.

Resident Relationships and Activities (Chapter 4)

- *Relationships in home*: About 80% of foster careproviders said they perceived residents primarily as family members, whereas group home staff most often perceived residents to be friends or trainees. Group home staff were less likely than ICF-MR staff or foster careproviders to know a resident's dislikes among foods or favorite possessions.

- *Household chores*: Among ambulatory adults who could talk, group home residents were most likely, and foster home residents least likely, to be expected to perform household chores.

- *Family contact*: About two-thirds of residents (69%) were reported to have regular contact with a parent or relative. Careproviders felt more should be done to involve natural families for one third of residents and half of all residents were reported to desire more family contact. About 13% of all residents were reported to have no known relatives, including 21% of the foster home residents. Careproviders considered other family commitments (20%), distance (19%), lack of interest (15%), and the resident's behavior (6%) the most common reasons for limited family contact.

- *Friendships*: About 60% of residents were reported to have one or more friends other than relatives or staff, with no significant differences by facility type. About half of all residents were reported to have a person they went to for help or advice, typically the foster parent, staff or relatives. Less

than one-quarter of residents were reported to have anyone who depended on them, and less than half were said to belong to a group that got together regularly at which they would be missed. Very few residents were reported to get along poorly with other residents. Most of the "best friends" of residents, other than staff, were other persons with handicaps in the homes or day programs. They were primarily of the same gender and age.

- *Neighbors*: About 70% of all residents had met at least one of their neighbors. Residents of smaller facilities had met neighbors more often (78%) than residents of larger facilities (66%). Small foster home residents were more likely to meet (87% vs. 67% of other residents) and to have been invited into neighbor's homes (51% vs. 24% of other residents). Neighborhood acceptance was reported to be relatively high. Only about 10% of foster and 20% of group home residents were reported to be avoided by neighbors, and very few (3%) were said to be received with hostility or annoyance. About 20% had experienced particularly positive incidents in the neighborhood and 11% particularly negative incidents.

- *Leisure participation*: Sample members engaged in a wide range of leisure activities. They participated in these activities with somewhat greater frequency than members of a comparison sample from the general population.

- *Leisure activities*: Activities engaged in by a majority of sample members at least weekly included listening to the radio, records or tapes, watching television, going for walks away from the facility, and participating in active physical exercise. Activities in which 25% to 50% of residents participated at least weekly included attending religious services, shopping, participation in bowling and other sports, visiting friends, and engaging in personal hobbies. Activities in which a majority of residents were said to participate "practically never" included writing/dictating letters (with or without assistance); looking at reading material; going to the library; entertaining friends; sewing, crocheting or knitting; going to a tavern or bar; or going on a date.

- *Facility differences in leisure activities*: Few statistically significant differences were noted among facilities in residents' participation in various leisure activities. Those noted included that foster home residents were more likely to be reported to practically never go to movies (43%), go shopping (25%), engage in bowling or other participatory sports (43%), go for a walk away from the house (17%), go to a tavern or bar (94%), go to a party or a dance (29%), or go on a date (93%). Differences between group homes and ICFs-MR were relatively minor, with group home residents more likely to shop at least weekly and less likely to take part in bowling and other participatory sports.

- *Leisure activity supervision*: Approximately 80% of residents were reported to need supervision for leisure activities away from the home. The primary source of supervision for residents needing it was staff of the residential facility. Most leisure activities were engaged in along with several other residents (38%) or all other residents (35%). About 10% of the time residents were reported to be individually accompanied by a careprovider. About 16% of foster home residents were reported to be usually accompanied by friends or by family.

- *Contact with nonhandicapped persons*: Slightly less than half of all residents, usually foster home residents, were reported to have regular social contact with nonhandicapped people other than staff or family. About one-third of those with contact with nonhandicapped persons were said to receive this contact primarily through church activities. About 22% received it through networks involving family, friends and present or past staff. About 12% received contact primarily through relationships with neighbors and 16% through leisure activities and outings.

- *Individual habilitation plans (IHP)*: There were no facility differences in the inclusion of self care skills in residents' IHPs; however, community living skills were considerably more often goals for group home and ICF-MR residents (75%) than foster home residents (45%).

Program Characteristics (Chapter 5)

- *Case management*: Over 95% of foster home and ICF-MR residents and 87% of group home residents had case managers. Foster and group home case managers were primarily affiliated with state, regional or county agencies. ICF-MR residents' homes were equally likely to leave case management from a state, regional or county, or provider agency. Most commonly, case managers visited monthly; about 15% visited residents every six months or less often. Foster parents generally felt case managers understood the resident's needs, abilities and problems very well; group home staff members were less favorable, indicating less frequent provision of the various service functions than respondents from other facilities. The typical case manager visited each resident about every one to three months for at least 30 to 60 minutes in duration. Case managers were reported to fulfill a number of functions, most related to monitoring the status of residents. Less emphasis was given to specific technical consultation on the needs of residents or in providing assistance to the providers.

- *Program plans*: Nearly all respondents reported availability of program plans with goals and objectives (87 to 97%). Small foster home providers were somewhat less likely than other programs to report available plans and to actively participate in their formulation. Respondents did not report themselves to be highly involved in formulating plans.

- *Day programs*: More than 95% of persons living in group homes and ICFs-MR and 90% of foster home residents had a day program outside the residential facility. Day activity center and sheltered workshop programs were the most common placements, with foster home residents somewhat more likely to be placed in day activity centers. Over two-thirds (69%) of residents attending school attended special schools rather than classes in regular schools. There was very little evidence of integrated day programs or community-based employment options for the sample. Over 80% of programs were within 20 miles, typically taking less than 30 minutes one way. Transportation was more likely to be provided by the program/other agency in foster homes, whereas group and ICF-MR homes were somewhat more likely to provide transportation. A majority of careproviders had contact with day program staff once a month or more frequently. Reasons for contacts were mainly related to logistical issues, training goals, behavior problems and the progress of residents.

- *Specialized services*: The majority of residents did not appear to have serious recurring medical problems requiring that they be seen by medical doctors. Problems in the availability of health care were infrequent and diffuse in nature. About 70% had seen dentists 1-2 times in the previous year. ICF-MR residents were most likely to use nursing and dietary services, and foster homes used slightly more occupational therapy, but both occupational and physical therapy were infrequent, as were counseling, psychological and speech therapy services. Social work services were more frequently received than other behavioral services. Overall, foster home residents were less likely to have seen medical specialists than other residents. The vast majority of residents received few if any services, with only about half of the residents in all facility types receiving any type of specialized service over the previous year. Most careproviders reported that residents did not need additional services.

Comparison With General Public (Chapter 6)

This study indicated that the community residential facility sample was generally much less well integrated into the life of the community than was a sample of the general population. Differences were greatest in the areas of vocational/educational integration and social integration. Differences were least and actually favored the sample of persons with mental retardation in community residential facilities in the area of leisure/recreational integration.

Conclusion

This study indicated that many persons with mental retardation, even those with severe mental, physical and behavioral impairments, are functioning well in small living arrangements in normal communities. High rates of satisfaction and relatively positive community and neighborhood acceptance were reported. The data in this study showed relatively high levels of community and domestic participation, with and without support, among residents of these programs. But the data also indicated limited vocational, educational and social integration, and efforts to prepare persons for more independent lifestyles. In general the study suggested that if culturally typical levels of integration and participation in the community are to be the goals of community living then increased efforts to promote them are needed. Some of these efforts may need to be tailored to specific areas for specific types of facilities (e.g., increasing domestic activities among foster home residents), but in the broadest sense the challenge appears to be primarily that of assuring that the positive levels of integration and participation reported for many members of the sample become more commonly available to all community facility residents. Despite the limitations of community facilities in assuring full integration, the most predictable way to social involvement, personal development, community participation, and independence for people with developmental disabilities in residential settings remains providing them the opportunity to live in a small community setting.

CHAPTER 1

BACKGROUND AND OVERVIEW

This report examines in considerable detail the most rapidly growing types of residential settings for providing supervised community-based care to persons with mental retardation and other developmental disabilities, specialized foster homes and group homes with 6 or fewer residents.[1] The study described was designed to provide a comparative look at such "facilities," the characteristics of the careproviders who work in those facilities, the characteristics of residents, and the programs, services, and experiences that contribute to their lives "in the community." The need for such a study derives from major changes that have been occurring over the past 20 years in the nature and locus of residential services for persons with mental retardation. Between 1967 and 1987 the average daily populations of state operated residential facilities for persons with mental retardation decreased by 100,000 from about 194,700 to about 94,700 (White, Lakin, Hill, Wright, & Bruininks, 1988). Although the number of persons with mental retardation in state institutions is still sizeable, this once predominant source of residential care now has fewer residents than facilities of 15 and fewer residents.

In recent studies of residential placements for persons with mental retardation in the United States two pronounced trends are evident: 1) a rapid decrease in the number of people in the very largest of residential facilities, and 2) a rapid increase in the number of people in the smallest facilities, especially those of six or fewer residents. For example, between 1977 and 1987, the number of residents with mental retardation in facilities with more than 300 residents decreased by 52% from 143,000 to 69,000. At the other extreme the number of residents with mental retardation in facilities with 15 or fewer residents increased from 40,424 to 118,570 over the same ten year period (White, Lakin, Wright, Hill, & Menke, 1989). While statistics on the number of people in placements of 6 or fewer residents are less readily available, there are many indicators of rapid growth in these smallest facilities.

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[1]Frequent reference is made in this report to alternative forms of residential "services" or "care." In this context these terms refer to a range of functions and responsibilities fulfilled by residential settings, including personal care, supervision, training and other "services."

For example, between 1977 and 1982 the number of people in facilities of 6 or fewer residents grew by over 60% from 20,400 to 33,200 (Lakin, Hill & Bruininks, 1985). A sample of 23 states reported 35% of their total population of persons with mental retardation as of June 30, 1988 to be in facilities of 6 or fewer residents. Assuming these statistics are nationally representative, approximately 90,000 persons with mental retardation would have been in facilities of 6 or fewer residents in June 1988. In 1982, nationwide, of all facilities licensed to provide long-term residential care for persons with mental retardation, two-thirds (67%) had six or fewer residents. In 1988 approximately 85% of all licensed placements (separate living units) had 6 or fewer placements.

The trend away from large facilities and toward placement in small, community-based facilities has been clear and relatively rapid. It is supported by prevailing principles of appropriate care and respect for persons with mental retardation (i.e., normalization and placement in the least restrictive, most integrated setting feasible), as well as a growing and convincing body of research regarding their habilitation. Virtually all states now have explicit policy objectives related both to reducing the number of people living in large institutions and increasing the number of people residing in small residential facilities (especially those of 6 or fewer residents). There is also a growing trend within states to limit newly developed facilities to sizes in the range of 5 to 8 residents (Lakin, Jaskulski, Hill, Bruininks, Menke, White, & Wright, 1989).

Two types of residential facilities house the vast majority of small facility residents--foster homes and small group homes. In foster homes, residents with mental retardation live in a residence that is owned or rented by individuals or families to serve as their own primary domicile. The primary goal of this model of care is to provide a normal family living experience for residents. In small group homes, residents live in a facility that is owned or operated to serve as a residential facility and paid staff members come to provide care, supervision, and training to the residents. While small group homes facilities attempt to emulate "typical" households, they generally also maintain a training orientation. Some of the distinctions between these two models are less clear in actual practice. Many small group facilities have live-in staff for whom the facility serves as their primary domicile. Many foster homes,

particularly those with 3 or more residents, hire part-time or temporary help for certain times of the day to perform specific household tasks, or to provide periods of respite for the careprovider family. Many foster homes provide training, sometimes through formal contracts, or more informally as part of the general concern for the well-being of the individual with mental retardation.

The last comprehensive national effort to count the number of foster homes and small group homes and residents was a 1982 survey that asked careproviders themselves to choose from among six definitions the one that was most descriptive of their facility (Hill & Lakin, 1986). At that time almost all (96.4%) of the persons with mental retardation in the smallest residential facilities (6 or fewer residents) were in facilities self-described as foster homes or group homes (as opposed to personal care, board and care, or semi-independent living arrangements). Of the nearly 33,000 residents of foster homes or small group facilities the number was nearly equally distributed between specialized foster homes (17,147 residents in 6,587 homes) and small group homes (15,701 in 3,557 homes). In 1986 the Inventory of Long-Term Care Places (ILTCP) attempted to survey all residential facilities for persons with mental retardation, including the smallest ones, to build a sample frame for the Institutional Populations Component of the 1987 National Medical Expenditure Survey. Unfortunately the ILTCP identification effort was particularly unsuccessful with respect to the smallest facilities, so much so that the 1987 National Medical Expenditure Survey dropped all facilities with 1 or 2 residents from its survey.

There are two primary reasons for looking closely at residential services and resident experiences in foster homes and small group homes. First, as noted, these are by far the fastest growing models of care within the various state residential care systems. A second and clearly related reason is that these types of facilities appear to be those that are best able to provide the kinds of residential experiences that the prevailing philosophy and psychology of care and habilitation suggest to be the most desirable, most appropriate, and most beneficial residential alternatives for persons with mental retardation. Before looking more closely at research regarding these specific models of residential care, the contemporary ideas and ideals that are propelling this rapid development of these small community based residential settings are briefly reviewed.

Prevailing Philosophy and Psychology of Residential Services

The Deinstitutionalization Movement

Over the past two decades dramatic changes have been taking place in long-term care services for persons with mental retardation and other developmental disabilities. These are reflected in the fact that the average daily resident population of persons with mental retardation in state mental retardation and mental health institutions in Fiscal Year 1987 was only 43% of the average of Fiscal Year 1967. The magnitude of this change has been due to the concerted effort to move the care of persons with mental retardation from institutions to community-based settings. This policy, termed deinstitutionalization, has been formally supported by every presidential administration since Kennedy's. It is also evident in the institutional population statistics of virtually every state. For example, between Fiscal Years 1985 and 1987 only two states increased their average daily population of state institutions (by a total of 26 residents), while nationally there was a decrease of 11,613 in average daily population of state mental retardation institutions (10.9%).

There have been a number of factors promoting the move from large public institutions to community-based residential programs. Among these have been the following:

1. ***Public exposes on the inadequate and often inhumane care provided in large institutional settings***: Among the most influential of these were Robert Kennedy's well-publicized unannounced tours of two state institutions, Rivera's televised visit to Willowbrook, and Blatt and Kaplan's photographic essay of life in state institutions.

2. ***Research documenting the dehumanizing and ultimately debilitating effects of the social systems in total institutions*** by sociologists and anthropologists including Goffman (1961), Vail (1967), and Braginski and Braginski (1971).

3. ***Civil rights movements and related judicial decisions***: A major tenet in the move to expand the civil rights movement to persons with disabilities has been the concept of normalization, i.e., the right to a life as culturally normative as possible. Since 1972 in the *Wyatt vs. Stickney* case in Alabama, a multitude of state and federal courts have supported normalization, recognizing that persons with developmental disabilities have a right to long-term care in the "least restrictive alternative" (i.e., the most culturally normative setting in which an individual can be adequately cared for).

4. ***Parent-consumer advocacy movement arguments for long-term care provisions that are as culturally normative as possible***: The Association for Retarded Citizens-United States and its state and local affiliates in particular have aggressively pursued, in courts and legislatures, the development of community-based services for persons with handicaps.

5. ***Research documenting the adaptability to community settings of persons with mental retardation*** who were released from institutional settings or who were placed directly into community-based alternatives (Edgerton, 1967; Jackson & Butler, 1963; Kraus, 1972; Krishef, 1959; Wolfson, 1956). More recently this research has been supplemented by reasonably well-designed longitudinal studies comparing the habilitative effects of community vs. institutional placements. A recent review by Larson and Lakin (in press) summarized the findings of consistent gains in adaptive behavior associated with moving from public institutions to community facilities.

6. ***Growing knowledge about the critical importance of the environment for instruction and learning, generalization, maintenance and adaptation for persons with developmental disabilities.*** It has become more generally understood that behaviors that are ultimately desired for certain settings are best learned in those settings, i.e., if one ultimately intends that persons with developmental disabilities participate in a community (or family, school, etc.), the required skills can be most effectively taught in the environment where the ultimate performance is desired. This is especially true for persons with more severe handicaps (Brown, Ford, Nisbet, Sweet, Donnellan, & Gruenewald, 1983; Falvey, 1986; Stokes & Baer, 1977).

7. ***The growing availability of federal funding alternatives for non-institutional care***: The availability of federal funds through Supplemental Security Income, Title XX support for community-based services, ICF-MR funding for small community-based residential facilities, and the enactment of the Medicaid Home and Community-Based Services waiver, have had a very significant impact on states' ability to provide funding for community-based care for persons with mental retardation (Boggs, Hanley-Maxwell, Lakin, & Bradley, 1989).

All of these factors have combined to create significant pressure to decrease populations of state institutions, with deinstitutionalization being the term coined to represent both the social policy and administrative process of depopulating institutions through releases and reduced first admissions. Critics have charged that the term deinstitutionalization has often been used to mean no more than the physical "placement" of individuals (Bachrach, 1981, 1985). Whether persons leaving large public congregate care facilities live less controlled or dehumanizing (i.e., less institutionalized) lifestyles, or are better integrated or more actively participate in culturally typical social settings, is too often ignored. While it is undeniably the case that community living for many people contains some of the most negative aspects of institutional living--group treatment, isolation, disoccupation (Bercovici, 1983)--it is equally clear that *in general* when compared with institutionalized persons, people living in community settings have substantially better integrated and more typical life experiences (Conroy & Bradley, 1985;

Felce, deKock, & Repp, 1986; Hill & Bruininks, 1981; Homer, Stoner, & Ferguson, 1988; O'Neil, Brown, Gordon, Schonhorn, & Green, 1981).

There have been in recent years two basic concepts which have both provided impetus to the deinstitutionalization movement and promoted better integrated and more typical life styles among those affected by deinstitutionalization, either through their being released from institutions or through their diversion from an initial institutional placement. Two concepts of importance in this regard are normalization and least restrictive environment.

Normalization

No term in recent years has been more influential on residential services for persons with mental retardation than "normalization." Normalization provides a moral as well as habilitative standard by which services to persons with disabilities can be assessed. Simply put, the standard is whether the conditions of daily life of the individual with a disability are as close to the cultural norm for a person of his/her age as the extent of the person's disability allows. Normalization provides significant counterpoint to attitudes and practices that once categorically assigned persons with disabilities to segregated and professionalized programs with virtually no recognition of their rights and potential to benefit from participating in their own community. Normalization is elegant in its simplicity, while providing a useful and egalitarian guide against which to examine the provision of care to persons with mental retardation.

As defined by one of its most noted proponents and primary developers Nirje (1976), normalization means:

> making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life of society. . . . a normal rhythm of the day, with privacy, activity, and mutual responsibility; a normal rhythm of the week, with a home to live in, a school or work to go to, and leisure time with a modicum of social interaction; a normal rhythm of year . . . opportunity to undergo the normal developmental experiences of the life cycle . . . respect and understanding given to the silent wishes or expressed self-determination . . . relationships between sexes. . . If retarded persons cannot or should not live in their family or own home, the homes provided should be of normal size and situated in normal residential areas. (pp. 231-232)

The normalization concept does not focus on services or habilitation per se. Instead, the principle of normalization promotes a standard of valuing an historically devalued group of people against which the appropriateness and quality of service can be judged, that is, whether the treatment of the individual reflects the acceptance of him/her as a rightful and valued member of the culture, allowing that person the opportunity for the maximally normal patterns and experiences of living that his/her disability reasonably allows.

Normalization as a philosophy and as a guide to professional practices has been in substantial opposition to practices of segregated treatment of persons with mental retardation. Such treatment obviously does not reflect recognition of persons with mental retardation as having an equal interest in participating in their own culture. In contrast the normalization principle contends that these interests are inherent in one's value as a person and member of the community, that they are primary interests, and that "treatment" must be subjugated to and in service of these greater interests. Advocates of normalization argue that it is the very nature of institutions to subjugate any interests that normally derive from their residents' community membership to the institutions' custodial and "habilitative" intentions.

The Least Restrictive Environment

Normalization is generally operationalized in the concept of the least restrictive environment (LRE). The LRE has been noted as the setting of choice by Congress in the Education for All Handicapped Children Act of 1975 (P.L. 94-142) and in the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 94-103), which reads, in part, as follows: "the treatment, services, and habilitation for a person with developmental disabilities . . . should be provided in the setting that is least restrictive of the person's personal liberty" (42 U.S.C. Section 6010). It has also had a major impact on day-to-day decisions regarding placement and program design by helping agencies and providers conceptualize services with range and flexibility in intensity that respond to developmental differences and developmental progress. In a general sense the concept of LRE can be seen as a marker for the general goal of providing services to persons with mental retardation in settings that afford the maximum

level of social integration while appropriately meeting clients' needs for care and supervision. But the "restrictiveness" of a setting is reflected not only in the degree to which it is isolated from the ongoing activities of the society and its citizenry. A setting can also be considered restrictive if it does not enhance personal growth and development. With respect to both opportunity for independence and integration and long-term personal development, the benefits of the relatively lesser restrictiveness of small, community-based settings over large institutions are becoming increasingly well documented (Lakin, Hill, & Bruininks, 1986).

In a comparative sense, the restrictiveness of settings is discernable, but the concept of the least restrictive environment for appropriately meeting the needs of a particular individual can be the source of considerable conflict. Critics contend that the lack of clarity of specific operational conditions for defining a least restrictive placement has caused the term to be misused. The most analytical and comprehensive criticism has been Taylor's (1988). He notes the following as significant limitations of LRE. First, that "the LRE principle legitimates restrictive environments," by assuming that placements can be meaningfully put on a continuum from least restrictive to most restrictive with people apportioned to those placements based on their levels and types of impairment. Second, that "the LRE principle confuses segregation and integration on the one hand with intensity of services on the other" by designating certain settings as being centers for responding to intense service needs, centers which often are also large, segregated, highly restrictive settings. Third, that "the LRE principle is based on a readiness model" which presumes that people should be moved from more restrictive to less restrictive placements based on their personal development rather than as a response to their basic rights. Fourth, that "the LRE principle supports . . . professional decision making" by suggesting that the extent to which people live in arrangements that are physically or socially integrated into the society should be within the discretion of professionals (pp. 45-47). These and other of Taylor's criticisms of the LRE concept, at least as it is operationalized, can be supported by data. For example, the fact that in 1987 there were about 60,000 people with profound mental retardation in state institutions (White, Lakin, Hill, Wright, & Bruininks, 1988) and only an estimated 16,000 in facilities of 15 or fewer residents

(Lakin, Hill, & Chen, 1989) strongly suggests that the least restrictive environment for people with profound mental retardation has in the past been perceived to be institutional care. On the other hand, more recent emphasis is being placed on people with severe handicaps who are demonstrating daily through successful experience in community settings that the least restrictive environment is a community-based living arrangement. This is reflected in the fact that while the total number of people with mental retardation living in community facilities increased by a remarkable 190% from 1982 to 1987, the number of people with profound mental retardation in community facilities increased almost as rapidly (170%).

Small foster homes and small group homes (no more than 6 residents) are generally regarded as representing the most normalized, least restrictive environments for extra-familial, non-independent living for persons with mental retardation. It is largely for this reason that they are the most rapidly growing models of care in the United States and have been targeted for continued rapid expansion in the plans and policies of most states (Lakin et al, 1989), and through major national policy reform proposals, most notably in the Medicaid Home and Community Quality Services Act (S. 384). In studying foster family homes and small group homes it is important to attend to the realization of normalization and less restrictive living for people in these settings. It is important to identify gaps that exist between the potential of such facilities and the realities of life in them. It is, therefore, important to examine how the ideals and goals of these models of care are reflected in the daily experiences of the people who live in them, in addition to gathering data on facility and resident characteristics.

Research which examines the typical patterns of community life in these facilities, including the social, leisure, and recreation activities of residents, the nature of their daytime activities, their access to and need for health and social services, and their involvement in activities and personal interactions is important in examining lives of persons living in these small facilities. In addition, research which looks at the attitudes and practices of careproviders in teaching and providing opportunities to perform skills of functional value, and in encouraging participation in culturally valued roles at the highest feasible level of independence, assists in evaluating this link between ideals and practices. This study

was designed to assist in responding to these needs. As such it adds to a growing body of research on foster homes and small group homes and their residents. Prior and current research in this area bearing on the issues addressed in the present study are reviewed in the following pages.

Foster Care

The origins of foster care for persons with mental disabilities have been traced as far back as the sixth century in Gheel, Belgium (Caplan, 1969). Examining foster care in this same city many centuries later, Doll (1934) noted that, in comparison with the institutional care then predominant in the United States, foster care was "both more economical and more satisfactory to the patient and his family than ordinary institutional segregation. The patient has the advantage of adequate medical care and social supervision, as well as the advantages of family life and personal freedom consistent with his disabilities and limitations" (pp.42-43).

Significant use of foster care as a long-term care option in the United States has occurred since the early part of this century (Lakin, Bruininks, & Sigford, 1981). New York and New Jersey's foster care programs for persons with mental retardation are over half a century old, having developed as part of the early efforts in deinstitutionalization in the 1920s and 1930s. These programs were seen then, as now, to present a number of important benefits over public institution and other congregate care placements. Pollack (1940) noted that they provided more natural and sociable environments for people to live in while demonstrating a considerable cost savings over institutional care. Such endorsements notwithstanding the enthusiastic development of the foster care model in the first third of this century fell into a period of stagnation in the second third, during which institution development became virtually the sole response to residential care needs.

In the final third of this century, as deinstitutionalization began to include people who were mentally retarded as well as mentally ill, foster care once again gained popularity as an alternative to institutions. According to Morrisey (1966), by 1966 about 6,000 persons with mental retardation were in generic foster care placements. By 1982 over 17,000 persons with mental retardation were in specially licensed foster care settings for persons with mental retardation (Hill et al., 1984) and another

14,135 children with mental retardation were identified as of December 31, 1985, to be in generic (county) foster care programs (Hill, Lakin, Novak, & White, 1987).

The stress on normalized, less restrictive, and maximally integrated residential alternatives (Wolfensberger, 1972) has led to a concerted search for models that provide life experiences which are as close as possible to the daily experiences of the general citizenry. Obviously, the foster care model has an inherent appeal in this regard, given the assumption that family care residents live in normal homes in normal neighborhoods, and participate in normal household and community activities.

The accelerated use of foster care has also been responsive to the increasing financial press on state residential services systems. The cost of long-term care has increased dramatically in recent years. For example, controlling for changes in the Consumer Price Index, the per resident cost of care in state institutions increased 295% between 1970 and 1987 (White et al, 1989). Although less information is available on cost increases among private facilities, between 1977 and 1982 average per resident daily costs nearly doubled, with an increase of 96.5% in nominal dollars and 60.5% in dollars adjusted for inflation. The magnitude of these cost increases have challenged states to carefully examine models of care that might reduce state expenditures. The simple per-resident per-day cost of specialized foster care is substantially below that of any other form of full-time, supervised care. Among small (6 or fewer residents) group homes in Fiscal Year 1982 the average per resident per day cost of care was $41.22; for foster homes the average was $16.15 (Lakin, Hill, & Bruininks, 1985). While it is sometimes the case that the average payment to foster care providers does not reflect all the costs that are typically included in reimbursements to other types of facilities (e.g., foster care residents may have small clothing allowances, may receive a limited number of paid respite care days, and costs of inservice training are less likely to be included in the reimbursement rate), clearly foster homes are substantially less costly on the average than staffed facilities.

The main issues in evaluating the foster home model are whether the model's potential for integrated, normalized living experiences for residents are actually realized, and whether the lower payments for care and supervision reflect lower qualities of care and supervision. It has been rather

clearly demonstrated that the lower costs of foster care when compared with staffed residences do not derive from a substantially different clientele. In 1982, 36.4% of foster care residents were severely or profoundly mentally retarded versus 37.8% of residents of small (1-6 residents) group facilities; 13.1% of foster home residents versus 9.4% of persons in small group facilities were not toilet trained; 9.3% of foster home residents were non-ambulatory compared to 7.4% in small group homes (Hill & Lakin, 1986). It should not be particularly surprising that small group home and foster home residents have similar characteristics, in that the primary factor predicting placement in one model or another is state policy with regard to its use rather than differential characteristics of residents (e.g., California and New York are traditionally heavy users of foster care).

While there has never been an intensive study of a *nationally representative* sample of specialized foster care settings, a number of investigations have examined the lives of persons with mental retardation in foster homes. Previous studies have varied somewhat in their conclusions. In the early 1970s, Baker, Seltzer, and Seltzer (1974) expressed some concerns about the family care model in that they noted that while residents were generally well-integrated into their foster families, they often were given few responsibilities and relatively little opportunity to develop independent living skills. They concluded that many foster homes were somewhat overprotective of residents when compared with small group homes, although the differences might have been somewhat affected by the greater average severity of retardation among their sample of foster home residents. They also commented on the particularly wide variation among placements, noting that, "Perhaps the absence of any discernable similarity in programming among community residences is the most outstanding characteristic of the foster home model. The operators of these homes tend to determine totally the quality of life within the home; and thus residents are dependent on the particular attitudes and skills of their family care operations" (p. 97).

Another observational study raising questions about whether the ideal of foster care was being realized was the Bjaanes and Butler (1974) comparative observation of two adult foster homes with 4 and 6 residents and two board and care facilities with 30 and 50 adult residents, all housing people

who were relatively mildly handicapped. They examined dimensions of physical environment, support to residents, attitudes toward residents, and the behavior of residents. Behavior was further broken down into active and passive leisure, work and chores, personal activity and social interaction. The authors noted large and systematic differences in the independent behavior among residents of the two types of facilities and concluded that the board and care facilities were more conducive to the promotion of independent behavior than were the foster care settings.

Other studies of the foster care model that have arrived at rather critical assessments of the programs studied include a study of Canadian foster homes by Murphy, Penner, and Luchins (1972). They concluded that not only did most foster care residents not participate in normalized social relationships to the point of interacting with typical citizens, they had relatively few interactions with members of the foster family. In fact, the authors argued that they found little advantage in the foster care arrangements of their subjects over the institutions where these individuals had formerly lived. Edgerton's (1975) intensive observations of individuals in foster care settings also have noted that many residents of such settings were living lives that were more restrictive and less integrated than those of residents of many considerably larger staffed residences for persons with mental retardation.

On the positive side, Scheerenberger and Felsenthal (1977) compared specialized foster care homes with group homes. They observed that foster care residents tended to enjoy greater autonomy and less group treatment than was the case for group home residents and that foster home residents were more likely to use generic community resources used by the general citizenry.

In a more recent study, Anderson, Lakin, Bruininks, and Hill (1987) compared foster care for older persons with mental retardation to other residential placements, including group homes of up to 15 persons, larger private facilities (16 or more residents) and state institutions. A 10% national sample of foster homes with one or more residents aged 63 and older was selected for study, for a total of 68 foster care homes and 96 residents. Residents of foster care homes were found to be remarkably similar to residents of other community placements in level of retardation, functional skills and a variety of health related indicators. Both qualitative and quantitative findings suggested that foster and group

home care residents made far more use of community facilities and services used by nonhandicapped persons (e.g., grocery stores, department stores, churches, restaurants, banks) than did residents of larger public and private facilities. Foster home care residents were most active in generic senior centers, and group home residents most active in leisure activities designed for persons with developmental disabilities. Foster care residents visited friends more often than other residents, were more likely to have nonhandicapped friends, and had been invited into neighbor's homes far more often than persons in any other residential placement. However, foster care providers appeared to be more reluctant than group home providers to involve residents in household chores, such as cooking and cleaning.

In perhaps the most comprehensive study of foster care to date, Willer and Intagliata (1982) compared 229 residents in 140 specialized foster care homes with 109 residents of 11 group homes in New York State. The groups were comparable in age (mean of 46 years) and roughly comparable in level of handicap (40% of the foster home recipients and 30% of the group care recipients were severely or profoundly retarded). All subjects were at least 13 years old and were former state institution residents living in a community-based setting for at least 2 years. The authors noted that residents of both types of homes were seen by caretakers as benefiting from their extra-institutional placement and that both groups used a wide range of resources within their communities. The authors noted, however, that there was as much variation within the two placement types as between them. In addition, other than cost, the absence of factors that differentiated between the types of facilities suggested that neither the nature nor the quality of care within the two care models was primarily a function of the models themselves.

While research on the effectiveness of foster care settings is quite limited, more recent studies using larger samples show somewhat greater degrees of community integration, friendships and opportunities for developing culturally useful skills than larger residential alternatives. It also represents the lowest cost alternative for out-of-home placement. As Willer and Intagliata (1982) noted in concluding their study, "Although cost alone should not be the primary factor determining the design

of a system of community residential care, it seems inevitable that cost-effectiveness will become an increasingly important consideration in shaping the delivery of all human services in the 1980s" (p. 594). When one looks at research comparing foster care settings with any other prevailing model of care the cost differential is hard to overlook. Capitalizing on that differential becomes even more attractive as consensus increases regarding the kinds of "products" that are desired of long-term care placements and the perception that foster care settings have a number of structural characteristics that provide and promote 1) living experiences that are culturally normal in pattern, context, and content; 2) interaction with a variety of persons including people who are not handicapped; 3) access to community setting for social, leisure and recreational activities; 4) integration into friendship and support networks; and 5) opportunities to learn the basic skills of daily living in one's own society.

Small Group Homes

Small group homes comprise the single most rapidly growing model of care in the United States. While maintaining the essential administrative and supervisory interrelationships that exist in large institutions (i.e., paid staff providing full-time programs of care, supervision, and training to the residents), small group homes are generally considered to offer more normalized and better integrated daily living experiences to their residents. Indeed, research comparing small group homes with larger group facilities (especially public institutions) tends to confirm that group home residents participate in social, domestic, and developmental/vocational activities that are much more normal with respect to their settings, structure, and participants than institution residents. Some of these studies demonstrate greater cultural normalcy of small group facilities (e.g., Rotegard, Hill, & Bruininks, 1983). Others have documented other somewhat predictable differences, such as the higher level of resident involvement in the local community, favoring group homes over institutions (Pratt, Luszcz, & Brown, 1980).

There have been 18 studies since 1976 that have provided longitudinal evidence of substantially improved adaptive behavior being associated with movements of institution residents to group homes of 15 or fewer residents. These studies, representing experimental/control groups, matched comparison

groups, or pre-test/post-test measures of adaptive behavior change, present extremely consistent evidence that there are substantial habilitative advantages associated with movement from institutions to small group homes (Larson & Lakin, in press).

A number of other aspects of daily living in group homes have been studied. Baker, Seltzer, and Seltzer (1974) compared small group homes, which they defined as having 10 or fewer residents, with larger group homes (10-20), and institutional settings (21 or more residents), and foster care homes. They found both small and intermediate size group facilities more actively involving residents in domestic activities than either family care or the institutional settings. They found small group homes and foster care homes similar in the extent to which they promoted resident autonomy. Their observations regarding the effects of some small group facilities (and foster care settings) were generally similar, if less explicitly stated, to those of Bercovici (1983) based on her intensive observations of life in various group residential settings in California. She concluded that "the circumstances of community placement for many retarded persons are institutional in nature. One prominent fact of this situation is that these retarded individuals have no more control over most facets of their existence than they did in the state hospital. Dependence, passivity, and inability to make decisions are some of the behavioral results of this continuing lack of opportunity for autonomy" (p. 189). Just as Baker, Seltzer, and Seltzer (1974) were noted above as having observed with family care facilities, Bercovici observed of small group facilities that, "The impression gained from the research experience was that the personal influence of the immediate caregiver on the client is greatly underestimated by planners of community care" (p. 202).

Comparative Studies of Foster Care and Small Group Homes

Despite the observation that in the smallest residential alternatives there is a substantial variability in quality that can be linked to primary careproviders, there have been a few studies which have directly compared the models. One study comparing foster homes and group homes was by Hull and Thompson (1980), who examined 369 individuals, about two-thirds of whom had previously been institutionalized, in the areas of self-care, community awareness, and social skills. They found that,

controlling for other predictors of resident skills, foster homes showed somewhat better general effects. A number of environmental and programmatic factors were identified that related resident achievement across settings, including geographical proximity to community resources, access to commercial, recreational, social, and vocational activities. In another study (Seltzer, 1981), foster care and relatively small group care facilities were compared on a number of factors related to domestic responsibilities, personal autonomy, community participation, staff attitudes and expectations, and the quality of habilitation activities. In each of these areas group homes were judged to be more effective than the foster care settings, whereas the ratings obtained for the foster care settings were generally more similar to those of institutional settings.

Willer and Intagliata's (1982) New York state study examined functional characteristics and change, social experiences, community participation, involvement with family and friends, and challenging behaviors relevant to the quality of life of 338 individuals residing in foster care and small group homes. Generally the findings of the study showed positive, similar resident outcomes for the two types of facilities. There were two areas in which statistically significant differences were observed: Community living skills ("topics related to independent living, such as travel, meal preparation, money management, and shopping," p. 590) and problem behaviors. With respect to the former, group homes had more desireable outcomes, whereas in the latter foster care settings were more effective. In examining the outcomes, the authors noted that the group homes they studied were generally larger than the foster care settings, but that when relatively small group homes were compared with relatively large foster care homes, that is, when facilities were roughly controlled for size, they were "almost indistinguishable" (p. 594).

In concluding this study, Willer and Intagliata noted that there is a need for additional research regarding the impact of a variety of community residential alternatives on persons with mental retardation. This study derives from continued recognition of that need. But given the nearly limitless number of areas in which these two models of care can be described and thereby compared, it is

important to look at previous efforts to examine the characteristics of community-based residential facilities and their residents.

Issues in the Study of Small Community Facilities

The following pages provide a review of the existing research methods and findings in efforts to describe the nature of community-based residential programs. These are discussed under general categories including Facility Characteristics, Community Characteristics, Careprovider Characteristics, Resident Characteristics, Programs and Activities, Specialized and Generic Services, Family Involvement and Friendships, Administration and Costs of Care.

Facility Characteristics

Facilities have been described according to numerous taxonomies. For example, Hill and Lakin (1986) reviewed existing taxonomies and recommended adoption of a three aspect taxonomy that includes program model, facility size, and facility ownership, with ICF-MR certification as an additional characteristic of interest. Each of the three aspects of the taxonomy was shown to be substantially related to a number of important service factors including cost of care, resident-to-staff ratios, and resident characteristics. Although ICF-MR certification was an important distinction in a few areas of interest (e.g., cost), generally it did distinguish well among facilities on many other key factors once the three primary aspects of the taxonomy were used. While such taxonomic descriptions are useful for descriptive purposes (and are used as such in this study), such general variables provide only a framework for the examination of residential programs. Even among these general facility descriptors, important interactions can be noted. For example, Jacobson, Silver, and Schwartz (1984) found that occupants in ICF-MR certified homes and in state-operated programs received greater number, and more total hours of services than group homes operated under a private proprietorship. But within the facility types, smaller homes provided more total hours of services to residents than larger homes. Service provision was also correlated with the degree of intellectual and functional limitations of residents, suggesting that individual need plays a substantial role in determining the services people receive. In addition, in describing facilities it is important to consider not only their taxonomic features,

but also their community of location and the characteristics, background, and attitudes of the careproviders which together structure the residential experience.

Model of Care. Baker, Seltzer, and Seltzer (1974), Intagliata, Willer, and Wicks (1981), and Willer and Intagliata (1984) have demonstrated that there is more variation between different types of settings than within a given setting type. On matters of considerable importance some foster homes are more like group homes than like other foster homes. It is also important to recognize that there is generally no agreed upon perception that one type of facility best serves one kind of individuals. Thus, although various characteristics of foster homes can be compared with group homes, it is important to keep in mind that these two types of facilities do not serve exclusive functions, nor are they targeted for a particular kind of individual. On the contrary, the process by which certain individuals are placed into particular facilities is not a planned, rational process. Several researchers have shown that the process of determining a placement type generally has little to do with the individual. Willer and Intagliata (1982), for instance, found that the year in which a person was placed into the community was the most significant factor in determining whether they went to a group home or a foster home; in certain years, different options were in favor at the state planning and funding level. In addition, Vitello, Atthouse, and Caldwell (1983) found that individuals have little certainty of ending up in the type of community environment for which they were recommended by placement staff. Little has apparently changed in the 25 years since Windle (1962) identified bed availability, year of placement, funding patterns, and county of residence as important determinants of type of placement.

Size. A significant amount of research has been conducted that has used "size" of facility, that is, number of individuals with mental retardation in one setting or building, as an independent variable for predicting important outcomes. Among the outcomes examined have been the extent of adaptive behavior change (Larson & Lakin, in press), community resource use (Hill & Bruininks, 1981), domestic activity (Horner, Stoner, & Ferguson, 1988), and so forth. In almost all instances, however, the research has compared very large facilities with samples of community facilities of different sizes, but including substantial numbers of facilities that were larger than those in the present study (6 or fewer). For

example, the study by Landesman-Dwyer, Sackett, and Kleinman (1980) of the relationship of size of community facility to resident and staff behavior did not include group homes with less than 6 beds. The focus on facilities of 6 and fewer residents in this study reflects a trend among the states to concentrate the development of new residential capacity in small facilities. Such facilities are not only by far the most rapidly growing today, but in a number of states new residential facilities are specifically limited to this size (Lakin et al, 1989). Within the present study, size of facilities is limited to 6 or fewer residents, but is further broken down into those with 4 or fewer residents and those with 5 or 6.

ICF-MR certification. In addition to model of care and size considerations, ICF-MR certification appears at times to be a significant as a descriptor for small group facilities. Small ICF-MR certified group homes (ICFs-MR) were over twice the daily cost of non-certified group homes in 1982 ($62.19 versus $30.58) and nearly 4 times the daily cost of foster care homes ($16.15). Group homes with ICF-MR certification have enjoyed a rapid rate of growth in recent years. On June 30, 1977, there were 188 ICFs-MR with 15 or fewer residents, on June 30, 1987, there were 3,098 residents (Lakin et al, 1989). The greater cost of such facilities, the stringent regulations governing their operation, and current attractiveness to several states, as reflected in the rapid development of this model, warrant special attention to the benefits derived from these much greater expenditures in the present study.

Community Characteristics

The characteristics of the local community have long been associated with the success of community placements (Lakin, Bruininks, & Sigford, 1981). Intagliata, Willer, and Wicks (1981) reported several community factors related to resident tenure, including especially service availability. They noted that better foster homes tended to be in urban rather than rural areas, where providers had better access to and were more likely to use recreational services and respite care. Slater and Black (1986) also identified significant differences between group homes found in urban areas and those in rural areas. People living in homes in rural areas received significantly fewer recreational, counseling, and sheltered employment services than those in urban areas. They also found that two basic services, medical/dental care and habilitative training, were considered to be adequate to meet the needs of only

20% of the residents living in rural areas. Other studies relating rural location to relatively poor service availability and/or utilization include Gotowka and Johnson (1982), who found evidence of inadequate dental care; and Bjaanes, Butler, and Kelley, (1981), who found training programs in rural areas to be inadequate.

While there is some evidence of rural-urban differences in the quantity and/or quality of services, it should be noted that relatively few studies have addressed this question, and those that have done so have looked at a very limited range of locations and types of programs. Of course, the discrepancies between the adequacy of urban and rural settings are not caused by location per se, but from the differential availability of key services and resources that derive from different densities of general and handicapped citizens. Successful efforts to respond effectively to the general problems of providing comprehensive services to persons with severe handicaps in rural areas have been described by Singer, Close, Irvin, Gersten, & Sailor (1984). Other geographic variables related to service and resource availability include state and local variations in service provision and financing that derive from general economic conditions, political choices, and degree of commitment to persons with disabilities.

Local communities obviously have more than just "services" to offer individuals with mental retardation. As Kastner, Reppucci, and Pezzoli (1979) have noted, "nothing is more essential to the eventual success of the community mental retardation services movement than the good will, acceptance, and support of the general public" (p. 137). Hypothetically, the general population appears to be accepting of small residential facilities (6 or fewer residents) in their neighborhood (e.g., a 1976 Gallup poll indicated that 85% of the population would not object to a small group home on their block [Gallup, 1976]). Perhaps more importantly, prior to the actual siting of a small group facility some community resistance appears to be encountered in about one-third of the cases, but after opening, opposition is reported by a very small percentage (2%) of facilities (Lubin, Schwartz, Zigmond, & Janicki, 1982; Seltzer & Seltzer, 1985). Nevertheless, acceptance of residential facilities by community members does not translate into community involvement in the lives of neighbors with mental retardation. Research has found the surrounding community of non-handicapped persons to be the source of few

social involvements for persons in residential settings (Bercovici, 1983; Birenbaum & Seiffer, 1976; Hill & Bruininks, 1981).

Careprovider Characteristics

The quality of the staff members who are in direct care roles frequently has been argued to be the single most important determinant of success in residential programming (Baker et al., 1977; Seltzer & Seltzer, 1974; Lakin & Bruininks, 1981; Robinson & Robinson, 1976). Evidence to support such observations is found in the work of a number of researchers, including Thompson and Grabowski (1972), Watson (1970), and Berkson and Landesman-Dwyer (1977), who have demonstrated that systematic changes in the behavior *of staff members* can lead to observable changes in the behavior of residents. Others have found careprovider characteristics associated with engagement in community activities (Dalgleish, 1983; Intagliata, Willer, & Wicks, 1981).

Demographic variables associated with effective foster parents. Numerous studies have attempted to identify characteristics of foster care providers which enhance the successful community adjustment and personal development of individuals with developmental disabilities. Retherford (1975) and Penniman's (1974) studies of foster parents found that age, maturity, and emotional stability were the most important predictors of success in caring for persons discharged from state institutions. They found that demographic variables other than age, sex, education, personal experience, marital status, religion, and number of children in the family had no predictive value. Sanderson and Crawley (1982) found that successful foster care parents were generally older and more frequently active in Protestant churches, but Sternlicht (1978) in an earlier study found that demographic characteristics such as sex, education, marital status, and religion failed to discriminate between successful and unsuccessful foster parents.

Other variables. Other factors which are found to be related to successful caregiving include Sutter's (1980) finding that caretaker experience and proximity of members of the caretaker's family (relatives lived nearby) to the home significantly influenced the success of foster placement and Browder, Ellis, and Neal's (1974) finding that acceptance of the child's handicap by foster parents was

correlated both with utilization of necessary services and with improvement in the child's emotional response.

Willer and Intagliata (1981) found that foster home providers who were better educated and had better mental health had greater success in teaching skills. Older providers were more successful at teaching self-care skills and younger providers were more successful at arranging for foster residents to take full advantage of community resources. These researchers also found that care provider attitudes and orientation were important to the successful adjustment of adults with mental retardation to community living. Care providers who were over-protective were less likely to encourage development of self-care or community living skills.

Intagliata, Willer, and Wicks (1981) reported that, based on ratings of nurses and social workers who were familiar with foster homes, providers in the "higher quality" homes were better educated, had more health-related training, were more disposed to seek out services and activities for their residents, were actively involved in their residents' treatment plans, had stable, well-organized homes, established "warm but not dependent" relationships with their residents, encouraged the residents to use community resources and to develop new skills, and had become family care providers because of their past experiences with persons with mental retardation. "Lower quality" providers were more likely to report their need for money, their desire to take care of someone, or having had a mentally retarded relative as major motivating factors. Lower quality providers were also more likely to report caregiving burdens, such as difficulties in managing the resident, being solely responsible for caring, and neglecting responsibilities to other family members. Higher quality providers were more likely than lower quality providers to report difficulties in getting free time away from residents.

Careprovider characteristics and practices in other community and institutional settings. A number of studies of direct careproviders have focused on their skills and practices. An earlier and particularly disturbing study by Landesman-Dwyer, Sackett, and Kleinman (1980) found that, across different size group homes, staff behavior was remarkably homogeneous and generally unrelated to facility or resident characteristics. The largest proportion of staff member time was spent in household

maintenance and general social activity, and less than one percent of staff members' behavior fell into the behavioral categories of actively praising, rewarding, defending, assisting, protecting, and sharing with residents. Repp, Barton, and Gottlieb (1983) studied 50 institutionalized males with severe or profound mental retardation, and found that clients were predominantly alone or with peers rather than with staff members, and when with staff members, it was typically with two or more peers, rather than one-to-one interactions.

Intagliata, Rinck, and Calkins' (1986) study of staff responses to maladaptive behavior found that both institution and community residence staff (including group homes, foster homes, and semi-independent apartments) encountered all types of maladaptive behaviors, but that community staff more frequently used verbal response strategies, whereas institution staff more frequently used physical responses. Staff response strategies with a behavioral orientation were significantly more likely to be successful in promoting improvements in behaviors. The authors conclude that there is good reason to suspect that staff are not adequately prepared and trained to manage behavior effectively. The study by Felce and colleagues (1987) of staff responses to the behavior of adult residents in a variety of institutional and community residential settings in the United Kingdom found that in the institutions and large community units, staff showed similar pattern of responses to appropriate behavior, but there was a lack of staff responding to inappropriate client behavior. In the small community houses, staff showed a greater rate of encouragement of appropriate behavior.

Staff attitudes, facility characteristics, and other factors associated with resident outcomes. Hull and Thompson (1980) examined several staff attitude variables, including optimism, stereotyping, promotion of independence, and consciousness of normalization. They found that these attitudes accounted for more variance in the adaptive functioning of clients than did individual client characteristics such as IQ. Zigler, Balla, and Kossan (1986), however, failed to support this finding. They found no relationship between resident management practices, direct careprovider attitudes or demographic variables and resident's responsiveness to social reinforcement, wariness, and outer directedness. The only resident variable related to these behaviors was mental age.

Staff training, recruitment and retention. Studies of staff and resident interaction have helped focus attention on the need for more effective staff training as well as for greater understanding of the factors which motivate staff to be better careproviders. This has been further reinforced by studies demonstrating greater staff effectiveness as a result of systematic training (Schalock & Harper, 1978; Schinke & Wang, 1977). Seys and Duker (1986) found that the addition of a "supervisory treatment package" consisting of (a) self recording and public posting, (b) daily staff meetings, and (c) supervisory feed back and prompting on staff-resident interaction to regular scheduled activities increased the amount of time staff engaged in training of residents and decreased the amount of time spent on custodial care as well as off task time. Emerson and Emerson (1987) investigated the barriers to the effective implementation of behavioral methods by institutional direct-care staff. The results indicated that although direct care providers did not have enough knowledge of behavioral methods, in general they considered this method useful. The results also showed some significant barriers by direct-care providers in an institution. These barriers can be grouped into 3 major areas as follows. The major barriers to the effective implementation of behavioral methods were the staff's inadequate understanding of behavioral methods, their orientation towards resident habilitation (which tended to be custodial), and constraints in the institutional environment including inadequate resources, lack of involvement in decision making, and a poor ward environment. They found that if any one link in this chain was weak, the whole process was jeopardized. In addition, they found that the more respondents knew about behavioral techniques, the more useful they felt these techniques to be with clients with mental retardation; the reverse was true for clients with psychiatric disabilities. Others have discussed or proposed new training models. Karan and Knight (1986), for example, emphasize moving away from traditional training systems to functional skills training with two complementary training models, including a pre-service model with considerable flexibility in entry-exit-reentry requirements, credits for practical experience and a continuing education model, both of which would emphasize coordination between the training and the service system. Cooper (1977) and Flanagan, Cray, and Meter (1983) discuss the role of consultants in training direct care staff. The latter describe the way that staff at Camarillo State

Hospital were trained in behavior modification by a mobile consultation and training team, together with the advantages of such a team in comparison to other methods of staff training, including the advantage of providing training in the setting and with the clients with whom it will be employed. They indicate procedures for implementation, and provide curriculum examples, staff training methods and evaluation procedures.

The need for training programs has been further accentuated by the serious problems in recruiting and retaining qualified staff members that have been noted frequently within community-based residential care programs. A nationwide survey of 2,000 community residential administrators (Bruininks, Kudla, Wieck, & Hauber, 1980) found that personnel management, including recruitment of qualified staff, reduction of turnover rates and staff training, was the most frequently identified problem in residential settings. A number of researchers have suggested that the high rate of direct-care staff turnover is one of the most serious problems in the provision of residential care (George & Baumeister, 1981; Lakin, Bruininks, Hill, & Hauber, 1982). George and Baumeister's (1981) study of 21 community residential facilities of various sizes reported that low pay, wide variation in work demands, lack of effective training and orientation methods, and lack of support for dealing with behavior problems were among the major causes of employee turnover. Slater and Bunyard (1983), in attempting to investigate the source of turnover and of staff problems, found that there was considerable lack of purpose and preparation among many residential staff. The majority of primary care staff viewed their main responsibilities as facility maintenance, basic supervision of residents' daily activities, and ensuring the safety and basic life needs of residents such as food, shelter, and clothing. Less than 25% of group home staff indicated resident training as a primary area of responsibility, and less than half of the staff were able to define or provide examples of basic training concepts such as modeling, praise, or punishment. The authors concluded that the attitudes and preparation of the majority of primary care providers are not conducive to promoting optimum behavioral growth of residents, that they do not perceive their role as being a teacher, and that if they did they would not possess the basic training skills needed to fulfill that role.

Lakin, Bruininks, Hill, & Hauber (1982) examined turnover in a national sample of 75 public and 161 private facilities. In public facilities high rates of turnover were related to the county's unemployment rate, age of facility, initial salary, location, percent of persons with severe/profound mental retardation (an inverse relationship) and per diem cost of care. In private facilities, the factors varied depending on the facility size and owner-operator status, with owner-operated facilities having the highest stability. Munro, Duncan, and Seymour (1983) suggest that, under certain circumstances, direct care provider's turnover has little negative effect on resident's behavior, and that the turnover of staff with certain negative characteristics may positively affect the behavior of residents. Cope, Grossnickle, Covington, Durham, and Zaharia (1987) report significant difference between the performance of institutional staff who planned to stay and those who planned to leave staff and suggest that staff turnover may be beneficial to the extent it is associated with the staff's job performance. In general, however, there is consensus that the current rates of turnover pose significant barriers to a well-trained, effective work force, which in turn affects resident's training and progress toward mastery of the skills needed for successful community integration. Finally, some have examined job stressors and supports among direct care staff (Bersani & Heifetz, 1985; Browner, Ellis, Ford, Silsby, Tampoya, & Yee, 1987). Browner et al found that the lack of control over their work was perceived to be a source of job stress by direct care workers in four distinct units of a state residential facility. Technicians in those units who had better social supports had fewer health problems. They saw themselves as a "team," had a good deal of interaction both verbally and socially, shared friendships outside the work place, and saw their supervisor as supportive and helpful and an advocate for them with the administration.

Resident Characteristics

In researching reasons for the success of community placement, characteristics of individual clients have received much attention, especially beginning with some of the earliest studies in this area. Several major reviews of research have included Heal, Sigelman, and Switzky (1978); McCarver and Craig (1974); Windle (1962); Sigelman, Novak, Heal, and Switzky (1980); and Craig and McCarver (1984). These studies have pointed out that individual characteristics and qualities of clients have, in

themselves, little bearing on the prediction of "success" (i.e., tenure) in community living. Sigelman and her colleagues (1980) for instance reviewed research on age, diagnosis, race, intellectual level, academic ability, personality, personal appearance, presence of physical handicap, vocational skills, psychomotor skills, and social skills. They and McCarver and Craig (1974) concluded that in nearly 200 studies, not one resident variable was an unambiguous predictor of community success. As an example, intelligence as measured by IQ affects community success unpredictably. It appears that, if anything, persons with severe retardation are more successful than clients with less retardation in living in community settings (Bell, 1976; Conroy & Bradley, 1985; Gollay, 1976; Jacobson & Schwartz, 1983). For most people, the idea that community adjustment relies solely upon the ability of an individual to "adapt" has been replaced by the recognition that community adjustment is a result of interactions among behavioral characteristics, tolerance, behavioral change, commitment, and a range of other factors that are difficult to isolate and/or quantify.

Much research in this area derives from a social ecological model (Berkson & Romer, 1980: Heller, Berkson, & Romer, 1981), which proposes that an individual's successful adjustment depends most on the fit between a person and the environmental characteristics. For example, Sutter, Mayeda, Yee, and Yanagi (1981) demonstrated that the match between community care providers' preferences for the type of client they wanted to work with and the actual characteristics of clients in group homes was significantly related to the success of the clients. Schalock and Jensen (1986) have recently proposed a measurement method for determining goodness-of-fit between placement setting and resident.

While resident characteristics are not directly related to the success of community-based placements, there are significant reasons for gathering data on the characteristics of individuals in these facilities. One clear reason is that the appropriateness of services is obviously related to the characteristics and preferences of individuals with mental retardation, including age, nature, and degree of disability, and personal preferences for activities. Another and increasingly frequent use of resident characteristics data is to identify particular applications of community-based care for persons who,

although similar to persons living in the community, may still be residing in considerably larger and less integrated settings. Finally, such data can be used to examine variations in the application of foster care and small group programs (e.g., in cost, in staffing patterns, in care provider training, in staff concerns, and needs) as they relate to resident characteristics. Such variations can then assist in planning new programs.

Many contemporary issues related to the characteristics of residents in small facilities derive from the fact that historically small group homes and family care homes have served primarily as placements for individuals with mild and moderate impairments. In the future, however, the majority of new admissions to such facilities will be persons with more severe cognitive, physical and/or behavioral disabilities. The maldistribution by level of disability among the small facility populations is indicated by the fact that 60.5% of the total public and private residential population of mental retardation facilities in 1982 was severely or profoundly retarded, but only 37% of the small (6 or fewer residents) group and foster care residents were from this group. Still, the 1982 percentage represented a 6% increase from 1977. According to the 1987 National Medical Expenditure Survey (Edwards & Edwards, 1989), 42% of persons with mental retardation and related conditions in small mental retardation facilities were persons with severe or profound mental retardation. Perhaps more impressively, given the rapid increase in the number of small facilities as well as the steadily increasing proportion of facility residents with severe and profound mental retardation, the total numbers of residents with severe and profound mental retardation more than doubled between 1977 and 1982, and more than doubled again between 1982 and 1987. Clearly the contemporary experiences of these nearly 20,000 individuals living in small group and foster care placements will provide considerable guidance to future community living experiences of the approximately 75,000 persons with severe or profound retardation still living in large residential settings.

While there is a relationship between intensity of placement and severity of disability, there is considerable overlap in the characteristics of persons with mental retardation among different service environments. Moreover, nearly all of the projected changes recommended for people in service

programs were directed toward anticipated placements in less restrictive community-based settings. While it appears that individuals in different service delivery programs vary in their functional and adaptive characteristics, it also appears that persons with quite severe disabilities are being served in a variety of family care, small group care, and community-based day program environments. Moreover, projected service needs and trends by providers strongly argued for development of more integration service and social opportunities in community settings.

Primary Day Programs, Activities, Training

There has been some concern that community-based residential placements may not provide the comprehensive programs required by residents (Bjaanes, Butler, & Kelly, 1981), nor be adequately supported by other programs and services vital to resident habilitation (e.g., Dybwad, 1969). The importance of daytime educational, habilitation, and/or vocational programs in conjunction with community-based residential placements is well recognized as playing a vital role in the provision of needed services. While the literature on such programs is far too vast for review here, it is worth noting how such programs fulfill important complementary roles to residential services in small facilities. The range and extent of these programs, varying according to location, age group and level of disability of clients, include three readily identifiable types of programs: 1) special education programs; 2) employment, vocational training, and sheltered work programs; and 3) developmental/day activity centers.

Special education programs. The passage of Public Law 94-142 (45 CRF 121a.544) made education of children and youth with disabilities the responsibility of their local public school system. Primary among the requirements of this legislation was that "all handicapped children between 3-21 years should receive a free appropriate education and that, to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, (be) educated with children who are not handicapped." States are obligated to search out school age residents of public and private residential facilities and offer appropriate programs to them, where necessary entering into program agreements with the facilities in which students with mental retardation

are living. The reauthorization of the bill extended services to birth. While only about 6,500 children and youth were in small group and specialized family care homes in 1982, the assurances of an appropriate education through P.L. 94-142 were major factors permitting the increased use of such placements in place of residential schools, public institutions and other settings providing "in house" education programs. Undoubtedly, this bill was probably far more significant in its relationship to the decrease in 1977 from 91,000 children and youth in all public and private residential facilities in the U.S. in 1977 to 60,000 in 1982, to 48,500 in 1987 (Taylor, Lakin, & Hill, 1989). With respect to the quality of its guarantee of an education to children and youth in community-based facilities, a 1979 interview study (Lakin, Hill, Hauber, & Bruininks, 1983) indicated that all but 5% of the residents of community residential facilities had some form of education program, although the percentage got progressively worse with greater degree of handicap (16% of school age residents with profound retardation). Presumably, but not necessarily, these figures have improved in the past decade.

Vocational training work programs. Vocational services focus on increasing an individual's independence and potential for productive activity (Horejsi, 1975). A severe shortage of comprehensive vocational training programs for people with mental retardation in community settings has been noted frequently and for many years (Hutt & Gibby, 1976; Laski, 1979; Luckey & Neman, 1975). In O'Connor's (1976) survey of community residential facilities nationwide, vocational services were among those most frequently cited as inadequate. In a survey of 160 facilities in southern California, Butler, Bjannes and Hofacre (1975) noted that only one-third of the surveyed facilities with residents over 18 years old had residents in programs that developed vocational skills or utilized vocational skills in work settings. The technology of preparing persons with severe disabilities with useful training for meaningful work has been developing for over a decade (Cortazzo, 1972; Gold, 1973; Katz, Goldberg, & Shurka, 1977). Today it is reflected in comprehensive curricula and well established and documented demonstration efforts (Kiernan & Stark, 1986; Rusch, 1986). Extremely rapid growth in the number of supported employment participants has been noted in a wide range of states in recent years (Minnesota Supported Employment Project, 1989; St. Louis, D., 1988), the supply for actual employment programs

has not kept pace with demand. The 1987 National Medical Expenditure Survey (Lakin, Hill, & Chen, in press) estimates that only 52.4% of persons with mental retardation in residential settings of 6 or fewer residents work for pay, as do only an estimated 64.7% of residents of facilities with 7-15 residents. Sheltered workshops remain by far the predominant vocational experience of people in community residential settings, with an estimated 44.8% of persons in 6 or less resident facilities and 52.5% of persons in 7-15 resident facilities engaged in sheltered work (85.5% and 81.1%, respectively, of people working for pay). These statistics show the residents of community-based facilities have a much higher likelihood of working for pay than residents of all sizes of residential facility (39%). The statistics also suggest considerable improvement in the opportunity to work when compared with a national survey in 1979 in which an estimated 32.7% of community residents worked for pay, including 26.7% in sheltered settings (White, Hill, Lakin, & Bruininks, 1984).

Developmental activity centers. Developmental activity centers (often referred to as day activity centers) generally provide prevocational, domestic or other practical training as well as social and recreational activities to adults with mental retardation. Adult developmental activity centers have traditionally functioned to provide programming for people who are beyond the age of public school programs. The intent of these programs is generally to promote the independence of participants through self-help, pre-vocational, and community participation skills while also providing social, leisure and recreational activities. Increasingly they are criticized for doing so by ignoring the natural transition in our culture at the end of schooling to work activities (Sailor, Gee, Goetz, & Graham, 1988). In a 1976 study of people released from public mental retardation institutions, Gollay, Freedman, Wyngaarden, and Kurtz (1978) found 30% of their adult sample's daytime placements were in day activity centers. Developmental activity placements were found to be more prevalent among residents with severe retardation (44%) than among residents with moderate (27%) or mild (19%) degrees of retardation. A 1979 study of persons in community facilities found 23% of its 18-49 year old sample in day activity centers and another 12% indicated to be in residential school classes (presumably equivalent to day activity centers) (White et al., 1984).

Support Services

Two assumptions of the move to community-based residential services for persons with mental retardation are that 1) when persons have need for specific services, supports and protections in community settings these can be as consistently and well-provided as for individuals in more centralized institutional arrangements, and 2) along with entry into natural communities will come participation in the activities and relationships in the community that make community-based living a decidedly more normal social experience. Some research has challenged these assumptions, at least in some locations. For example, Bjaanes, Butler, and Kelly (1981) concluded that a fuller array of services is generally available to residents of California state institutions than to persons in private facility placements. Such data have led some to conclude that there are limits to the extent to which deinstitutionalization ought to be allowed to proceed without demonstration that the needed services are established and awaiting people leaving institutions. For example, Meyeda and Sutter (1982), in evaluating Hawaii's patterns of institutional depopulation stated that "deinstitutionalization goals should be reevaluated based on a consideration of the characteristics of the clients available for placement and the capabilities of the community to provide the services they need (1981, p. 380). Of course, such data arguably speak much less to the need for reconsideration of deinstitutionalization than to the need for development and assurance of access to needed services for persons living in community settings. Service availability is a frequently mentioned problem among private, community-based facilities. O'Connor's 1973 survey of 611 private residential facilities found one-quarter (24%) of their respondents citing the lack of community support services as one of the three most serious impediments to establishing and operating programs (O'Connor, 1976). In a survey of superintendents of 176 state institutions in 1979, Scheerenberger (1981) found the most frequently identified "major constant problem" in bringing about deinstitutionalization was the lack of community support services for adults.

Perhaps the most comprehensive study of services available to individuals with mental retardation in residential facilities was the 1979 interview study by the Center for Residential and Community Services (CRCS) of approximately 1,000 residents each of public and private residential

facilities (Hill, Lakin, Sigford, Hauber, & Bruininks, 1982). With respect to these samples it is important to note that private facility residents were sampled roughly in proportion to their distribution among all private facilities in 1978-1979 and therefore tend to be from facilities of considerably larger average size than those in the sample of the present study. In Table 1.1 comparing service utilization of private residential facility residents with residents of public facilities (state institutions), fewer private than state facility residents were reported to have had contact with physical, occupational, and speech therapists during the previous year, although in terms of the proportion of residents actually receiving services at the time of the interviews, statistically significant differences were not found. Private facility residents were more likely than state institution residents to have received counseling, to have participated in social/recreational activities outside the facility, or to have used transportation services other than those operated by the facility itself. Generally, a relatively low percentage of both public and private facility residents were reported to have needed services assessed in the study, but to not have had them available.

The CRCS study also assessed the frequency of service utilization by public and private residents who were using selected services in January 1979 (see Table 1.2). Statistically significant variations were noted in the frequency of services used on at least a weekly basis, especially counseling (10.5% of private and 3.4% of state facility residents), physical therapy (7% and 12.4% respectively), and speech therapy (18.3% and 11.5% respectively). Direct comparisons between the two types of facilities shown in Tables 1.1 and 1.2 should be viewed cautiously for a number of reasons. First, the differences in services received appear as easily associated with variations in the characteristics of residents of the two types of facilities as with their types of operation (e.g., 75% of state institution residents in the sample were severely or profoundly retarded versus 37.5% of private facility residents). Second, the main variations between public and private facility service provision came in the proportions of residents having been evaluated rather than the proportion actually receiving service at the time of

Table 1.1

Services Used by Residents of Private and Public Facilities During a One-Year Period and Services Needed but Not Available

Service	Private facility residents (N=969)		State institution residents (N=991)	
	% using services	% needing services not available	% using services	% needing services not available
Medical	97.3%	.5%	99.5%	.4%
Physical exam	90.0		87.8	
Treatment	45.2		61.2	
Dental	82.5	1.6	95.6	.5
Counseling		3.6		3.2
Receiving during year	25.3		15.3	
Presently received	20.1		9.6	
Physical therapy		3.9		6.1
Evaluated during year	19.6		32.7	
Received therapy during year	11.2		18.7	
Total	21.6		38.2	
Presently receives therapy	8.6		13.0	
Occupational therapy		3.1		5.8
Evaluated during year	21.3		32.9	
Received therapy during year	11.4		16.3	
Total	22.2		36.7	
Presently receives therapy	9.6		11.2	
Speech therapy		6.9		6.8
Evaluated during year	34.4		50.6	
Received therapy during year	23.0		17.1	
Total	39.1		56.5	
Presently receives therapy	19.0		12.3	
Outside/social recreations	61.4	8.0	34.5	7.1
Outside transportation[a]	68.0	2.3	15.9	2.1

[a]Besides what is offered by the residential facility. Outside transportation provided by family or friends or by the resident him/herself (bicycle, own car, or public transportation).

the study. This difference may reflect as much the on-staff versus referral provision of therapeutic services in public versus private facilities, with the former more likely to perform evaluations according to a schedule rather than referral because of expected need. Third, differences in service referral and

service usage may be more related to the requirements of regulations, notably ICF-MR regulations, than to the actual documented needs of persons in residential programs.

Table 1.2

Frequency with Which Residents Were Presently Receiving Selected Services

Service/ Frequency	Private facility residents (N = 964)	State institution residents (N = 996)
Medical Doctor		
more than twice per year	19.3%	11.8%
2 per year	18.8	16.0
yearly	54.8	70.8
less than yearly	.9	1.0
Counseling		
daily	.6	.3
2-6 per week	3.0	1.2
weekly	6.8	1.9
1-3 per month	6.4	1.6
less than monthly	2.5	3.4
Physical therapy		
daily	3.3	6.1
2-6 per week	2.3	5.9
weekly	1.4	.4
1-3 per month	1.0	.3
less than monthly	.2	.1
Occupational therapy		
daily	2.4	3.9
2-6 per week	4.4	5.6
weekly	1.9	1.2
1-3 per month	5.5	.1
less than monthly	-	.1
Speech therapy		
daily	3.4	3.9
2-6 per week	10.0	6.0
weekly	4.9	1.6
1-3 per month	.2	.4
less than monthly	.3	.1

Other studies have suggested that services for persons in community-based facilities are generally adequate. Gollay, Freedman, Wyngaarden, and Kurtz (1978) noted that none of 11 selected key services was reported as needed, but unavailable to at least 10% of their sample of 440

deinstitutionalized persons. O'Connor (1976) found that for over 600 residents of group homes only counseling was indicated as a needed but unavailable service for 10% of the residents.

Intagliata, Crosby, and Neider (1981), in summarizing results of the family care studies of Intagliata and Willer, reported general adequacy of support services for persons in family care in New York State. They noted universal access and use of medical care as needed. Respite care was reported to be nearly always available to family care providers (90%) and most often used (90%). Recreational services were reported to be available to 85% of family care homes and used by 76%. From 70% to 80% of family care homes reported availability of needed counseling, physical therapy, and speech therapy services. On the other hand, transportation was indicated as a difficulty for 43% of family care providers.

Community Activities

Much of the impetus for community-based residential placements has derived from the logical assumption that such placements naturally lead to increased participation in community activities and increased utilization of community resources. A primary implication of the normalization principle is that in addition to living in culturally typical housing arrangements and engaging in the most productive feasible and integrated daytime activities, persons with mental retardation will be integrated into normal community life by participating in typical leisure, social/cultural, economic, and related roles. Wolfensberger (1983) has suggested further amplification of the normalization principle to include not only recognition of the birthright of people to live and participate in their native culture and the necessity of such participation to learning the ways of their culture, but also social role valorization: "the establishment, enhancement, or defense of the social role(s) of a persons or a group by the enhancement of people's social images and personal competencies" (p. 234).

But the personal, cultural, and habilitative values of participating in community activities notwithstanding, it has been noted that many individuals living in community settings participate in those communities less than might be expected or desired (Baker, Seltzer, & Seltzer, 1974; Bjaanes & Butler, 1974; Calkins, Walker, Bacon-Prue, Gibson, Martinson, & Offner, 1985; Crapps, Langione, & Swaim,

1985). Researchers have noted for many years that leisure, recreation, and other participatory activities are important to the quality of community living for persons with developmental disabilities (Bell, Schoenrock, & Bensberg, 1981; Eyman & Call, 1977; Gollay, Freedman, Wyngaarden, & Kurtz, 1978). In response to this recognition leisure skills training techniques and curricula have been developed to promote such activity (Putnam, Werder, & Schleien, 1985; Schleien, Kiernan, & Wehman, 1981; Voeltz, Wuerch, & Wilcox, 1982; Wuerch & Voeltz, 1982).

Not all research has suggested low levels of community participation. Studies of foster home settings have generally found residents to be reasonably active participants in community activities (Baker, Seltzer, & Seltzer, 1974; Scheerenberger & Felsenthal, 1977; Intagliata, Willer, & Wicks, 1981). For example, Intagliata, Willer, and Wicks' (1981) summary of 128 family care residents' use of time over a three month period showed 93% eating at a restaurant, 90% using a barber or beauty shop, 82% attending church, 86% attending parties, 74% using a park, 40% going swimming, 45% going to a zoo, 35% going camping, 20% attending a ball game, 22% going to a museum, 18% going to a library, and 4% going to a bar at least once over the period. In comparing the community access of family care residents with that of small group home residents, no substantial differences were noted (Willer & Intagliata, 1982). Among the factors predicting community resource utilization were resident age and careprovider characteristics, including orientation to recreational activities, moral-religious orientation, and "psychological well-being" (Willer & Intagliata, 1981). A more recent study that focused on 231 older persons with mental retardation (63 years or older) also found community participation to be similar for residents of foster homes and group homes (Anderson, Lakin, Bruininks, & Hill, 1987). Community participation over a one month period included 85% going to a department or variety store, 75% going to a grocery store and 57% going to a local park. Like other studies (Bell, Schoenrock, & Bensberg, 1981; Dalgleish, 1983; Gollay, Freedman, Wyngaarden, & Kurtz, 1978; Hill, Rotegard, & Bruininks, 1984), the Anderson et al. study found residents with more severe mental handicaps to be less active participants in their communities than people with less severe impairments.

Domestic Activity

Research has generally shown that persons living in community settings are more actively involved in maintaining their domestic environment than are people living in institutional settings (Horner, Stoner, & Ferguson, 1988; Lakin, Anderson, Hill, & Chen, 1989). Involvement in domestic activities varies considerably from facility to facility, with more severely handicapped residents less likely to engage in household activities (Hill, Bruininks, & Lakin, 1983; Lakin, Anderson, Hill, & Chen, 1989). Mansell, Jenkins, Felce, and DeKock (1984) concluded from their research that while engaging persons with severe and profound levels of mental retardation in domestic tasks is a challenge, it is one that can be remedied through staff training and development.

Family Involvements and Friendships

Family involvement. Maintaining the involvement of family members in the lives of persons with mental retardation is an important goal for residential services systems. As Brotherson, Backus, Summers, and Turnbull (1986) note, "Family members are virtually the only constant figures in the developmentally disabled person's life. No service provider will follow him or her throughout life or across a multiple range of needs. Only a family has a broad enough perspective to take in the total picture of service needs" (p. 37).

Although maintaining family involvement in the lives of persons in residential settings has certain self-evident merit, there has been relatively little research on its substantive benefits or factors related to family involvement. One of the few studies attempting to document the benefits associated with family involvement was a 1971 study by Balla and Zigler. They found in a study of institutionalized children that visits with parents were associated with greater independence and less wariness of adults. These relationships were stronger the lower the mental age of children. On the other hand, D'Onofrio, Robinson, Isett, Roszkowski, and Spreat (1980) found that there was no relationship between parental contact and the individual residents' adaptive behavior.

Researchers have also looked at factors predicting the amount of family involvement in the lives of persons in residential settings. In their institution study, Balla and Zigler (1971) found reports of the

relationship between parents and children prior to institutionalization to be the best predictor of parental involvement after placement. The level of retardation of residents was unrelated to parental involvement; distance between the family home and the institution was only slightly related. Anderson, Schlottman, and Weiner (1975) found three factors related to parental involvement. The first factor related to low extent of involvement was the distance from the institution. Another factor predicting relatively low involvement was comprised of resident characteristics, especially physical anomalies and low social maturity. A third category of predictors of low involvement was family characteristics, including occupational level by father, absence of family contributions to the cost of care, and remarriage of custodial parent. Klaber (1968) disputed the relationship between distance from home and parent involvement, suggesting the facility quality predicts parent involvement (although his sample size of only three institutions makes this generalization somewhat risky). D'Onofrio et al. (1980), on the other hand, found a relationship between distance from the parents home to a facility and the frequency of parental visitation. They also found intact marriages to be predictive of more frequent visits.

In comparing residents of group homes with residents of foster homes, Willer and Intagliata (1982) found that residents of the two types of homes had a similar degree of contact with outside friends and family members. Again, client characteristics had little bearing on the likelihood of contacts with relatives. For both types of homes, the primary factor affecting the amount of family contact and overall social support of residents was the attitude of individual care providers and their efforts to encourage and engineer such social contacts.

Research studies of family relationships have also focused on parental attitudes about, and often opposition to, proposed and/or accomplished movement of their children from institutional to community settings (Meyer, 1980; Willer, Intagliata, & Atkinson, 1981). The best examples of this research are from the Pennhurst Longitudinal Study (Conroy, 1985; Latib, Conroy, & Hess, 1984). Generally these studies showed that opposition on the part of a majority of parents to movement of their children out of the Pennhurst Center (a Pennsylvania state institution) into small community based homes turned to overwhelming satisfaction (82%) after the move had taken place and was demonstrated to be

successful. Despite improved satisfaction, however, the proportion of parents who visited their children at least once a month increased only from 44% prior to the move to 53% after placement in community residences.

Table 1.3 presents data on family visits from interviews with careproviders regarding the approximately 1,000 private and 1,000 public facility residents Hill and Bruininks (1981) studied. Their results showed greater proportions of private facility residents to have contact with family members, and that visits with family members of private facility residents to be more frequent and more often to include visits to the homes of family members.

Table 1.3

Percentage of Residents by Place and Frequency of Contact with Relatives

Activity	Private facility residents (N = 951)	State institution residents (N = 996)
Residents visit with relatives	79.8%	63.2%
Visit only at facility	16.2	28.4
Visit only at relative's home	15.7	6.6
Frequency of visits at a relative's home		
Several times/week	1.1	.1
Once/week	6.6	1.4
Several times/month	10.2	3.8
Once/month	9.1	3.6
Several times/year	27.2	16.4
Once/year	9.7	10.0
Frequency of visits at facility		
Several times/week	1.6	.5
Once/week	6.3	2.6
Several times/month	8.1	5.7
Once/month	10.4	7.1
Several times/year	25.1	28.0
Once/year	13.4	13.9
Contact but no visits	3.9	5.3
No contact	16.5	31.0

Friendships. Friendships are obviously an important aspect of the lives of persons with mental retardation, as they are for persons who are not retarded. Edgerton (1967) documented clearly the importance that nonretarded friends can have in the adjustment of deinstitutionalized persons. Gollay,

Freedman, Wyngaarden, and Kurtz (1978) found the absence of friends to be strong predictors of whether persons moving from institutions to community-living would be reinstitutionalized. They reported that almost all of their sample (99%) remaining in the community had friends, while only 59% of those reinstitutionalized did. An obvious factor in this relationship is that behavior patterns which discourage friendships may also reduce the probability of community placement success.

In recent years there has been increased attention on the importance of social relationships to people with developmental disabilities (O'Brien, 1987; Taylor, Biklin, & Knoll, 1987). Community living, in and of itself, does not appear to be the source of as many friendships as might be desired. Findings from qualitative and follow-up research studies (Bercovici, 1983; Bruininks, Thurlow, Lewis, & Larson, 1988) document that physical integration of adults with handicaps in community settings does not guarantee the establishment of social and interpersonal relationships. O'Connor (1976) reported that 57% of all residents in community residential facilities had friends from outside the facility, and that 46% of residents visited outside the facility with those friends. Birenbaum and Seiffer (1976) were able to identify few friendships away from the residential or day programs for the Gatewood residents they studied and saw little evidence of the benefactor relationships with nonhandicapped friends that were so important to the persons in nonsupervised living arrangements who were studied by Edgerton (1967).

In a national interview study of about 2,000 handicapped people (Hill, Rotegard, & Bruininks, 1984), careproviders were asked about special friends of residents (someone who did things with a resident outside of the job role, and with whom resident looked forward to doing things). For residents with no reported friends, questions were asked about special relationships other than family members who might take a special interest in a resident. The results of this study, shown in Table 1.4, documented that private, generally smaller community-based facility residents were more likely than state institution residents to have friends, although a discouraging number of persons in each type of facility had no one that staff could identify as having a friendship or unpaid special relationship with residents (42% of private facility residents and 63% of public facility residents). Social isolation is a theme common in other research as well (Calkins, Walker, Bacon-Prue, Gibson, Martinson, & Offner, 1985; Crapps, Langione, & Swaim, 1985; Malin, 1982).

Table 1.4

Percentage of Residents
with Friendships and Special Relationships

Activity	Private facility residents (N = 964)	State institution residents (N = 996)
Personal friends	50.4%	24.6%
Special relationship	7.5	12.2
Total	57.9	36.7
Type of Friend		
Peer	26.2	11.1
Facility staff	10.0	9.1
Volunteer, advocate, foster grandparent	10.8	4.3
Romantic friend	9.4	2.5
Current teacher or boss	3.6	1.7
Former staff	1.8	1.1
friends of family	2.0	.3
Another program's staff	.8	.7
Someone from church	1.3	.1
Neighbor	1.0	.1
Other	1.6	.3
Type of Special Relationship		
Peer	1.1	.7
Facility staff	5.3	9.8
Volunteer, advocate, foster grandparent	.6	1.3
Romantic friend	.1	.1
Current teacher or boss	1.3	.8
Former staff	.4	-
Friends of family	-	.2
Another program's staff	-	.4
Someone from church	-	.1
Neighbor	.1	-
Other	.2	.1

With respect to persons in family care settings, Willer and Intagliata (1984) noted that in their study, foster home residents who were interviewed all indicated at least one person "with whom they enjoyed getting together and on whom they could depend" (p. 59), but that commonly the friends named were peers in the residential settings. Willer and Intagliata also reported that comparisons between family care and group homes in New York State showed both to be similar in the degree to which friends were likely to be invited to the facility, but that the residents of the former were more likely to have neighborhood friends. The authors concluded that such friendships were likely facilitated for family care residents by the relationships already existing between family care providers and their neighbors.

Stimulated both by the rather disappointing findings regarding the relatively few and sporadic friendships between persons with mental retardation in residential settings with persons living outside those settings, and by the obvious reality that friendships will be most common with peers in the residential setting, there has been considerable effort in recent years to study friendship patterns in residential settings. Landesman-Dwyer, Berkson, and Romer (1979) conducted an observational study of 208 residents of 18 group facilities. They found that close physical proximity occurred between residents in 28% of the observation periods. They found overall facility characteristics such as average level of retardation (higher), age (older), and sex (female) of facility residents, and size of facility (larger) were related to higher levels of interaction/close proximity. Continued observational research and analysis by Berkson and Romer (Berkson, 1981; Heller, Berkson, & Romer, 1981; Romer & Berkson, 1981) led to a number of conclusions about friendship among individuals in residential and day programs for persons with mental retardation. Among these were that specific types of programs were not related to the social relationships of residents (Berkson, 1981), but that the social climate of programs strongly influenced the social behavior of people admitted to them. A number of individual characteristics were also noted to be related to interpersonal relationships, including age, sex, IQ, and desire for affiliation. The generally low number of friendships experienced by persons with mental retardation in residential settings, the recognition that the setting itself tends to be the primary source of friendships for individuals, and the identification of factors affecting the number and intensiveness of social relationships has drawn attention to friendship and interpersonal interrelationships as an important aspect of residential services. As Romer and Berkson (1980) noted with respect to their research, "the results of this study and others (Edgerton, Bercovici, 1976; Gollay, Freedman, Wyngaarden, & Kurtz, 1978) suggest that affiliation and friendship are an integral aspect in the lives of disabled individuals that deserves attention in rehabilitation and programming" (p. 250).

Costs of Care

Since the shift from public to private management in residential service delivery began, researchers have been particularly interested in comparing costs among different types of facilities. For the most part the results of these studies must be viewed with considerable caution. Many complex

methodological problems are involved in such research and these are compounded by the substantial variation among services provided in institutions and community-based facilities which lessen the accuracy and appropriateness of most cross-model comparisons.

No national study gathering cost data on residential facilities for persons with mental retardation has ever been structured so as to gather data on a full set of comparable and comprehensive services for persons living in different types of facilities. A number of studies within much more localized areas have gathered relatively comparable cost information for public institutions and generally small, staffed community-based facilities. Five studies that have gathered the most comparable data on the costs for persons residing in total institutions and community-based settings are summarized in Table 1.5.

A general conclusion derived from these relatively well-controlled studies would be that when comparable and comprehensive services are included in the total computed program costs for residents of different types of staffed residential facilities, the total costs of these programs are fairly similar. Comprehensive "community" programs had costs that were from 75% to 92% of total public institution program costs. The median finding was that the community-based programs were costing 86% of the institutional programs. Such differences are certainly significant, and for program cost estimation and policy analysis purposes they are important. On the other hand, they are much closer than average reported facility reimbursement rates, which in 1982 averaged $86 per day for large public institutions (16 or more residents) and only $41 for small group facilities (6 or fewer residents). Statistics such as those reported in Table 1.5 represent a far more realistic indicator of the kinds of savings that might accrue in continuing movement of persons with mental retardation to community living arrangements than the simple aggregation of facility revenues. Realistically, too, such differences should not be viewed as structural. The single most important factor in the variability noted among these studies is personnel costs (Wieck & Bruininks, 1981). The cost of staff makes up most of the costs of residential programs, and at present staff of small community-based facilities generally earn considerably less than their unionized, public employee counterparts in state institutions (Ashbaugh & Allard, 1983; Lakin & Bruininks, 1981). Maintenance of the current differential is by no means guaranteed.

Table 1.5
Studies Gathering Comparable Cost Data on Residents of
Public Institutions and Community-Based Facilities

Study/Author(s)	Year	Residential Programs Compared	Types of Costs Included	Notes on Costs Included	General Findings
Minnesota Department of Public Welfare	1979	Public ICF-MR institutions and private community (ICF-MR) facilities in Minnesota	Residential, day programs, transportation, social services, (case management, family support, etc.), medical services	Cost of components calculated only for individuals in private facilities, presumed covered in institution per diem. Institutional capital not included.	Higher average annual costs in the state institution ($19,500 to $17,900 per year)
Touche Ross & Co	1980	Beatrice State (ICF-MR) and community-based mental retardation (CBMR) programs (non-ICF-MR) in Nebraska	Residential, day program, support service (physical & speech therapy, transportation, etc.) social service (case management, social work), administration	Costs of components computed on a per client average from budgets of 6 CBMR regions. Beatrice State cost components extracted from facility budget. Medical costs for CBMR clients based on average of state Medicaid billings. Institution capital not included.	Average annual costs for persons in CBMR programs ($15,400) was less than in Beatrice State Hospital ($19,500)
Jones, Conroy, Feinstein & Lemanowicz	1983	Pennhurst State (ICF-MR) and community residential facilities (CRFs) with average bed size of 3.2 clients in Pennsylvania	Residential, day programs, entitlements, medical costs, case management, other	Study based on a matched sample of 70 former and 70 current residents of Pennhurst. Costs of components calculated for individuals in both CRFs & Pennhurst.	Average annual costs for persons in CRFs ($40,300) was less than in Pennhurst State School ($44,200)
Bensberg & Smith	1984	Public ICF-MR institutions and small (less than 15 res.) ICF-MR facilities in Texas	Residential (food, rent, utilities, phone, maintenance, staff), support services (day services, transportation)	Costs of components calculated only for individuals in small facilities, presumed covered in institution per diem. Institution capital not included	Lower average annual costs in small ICF-MRs ($18,350 to $21,250) without including administrative costs in small facilities. Costs higher in small facilities if agency administrative costs are included ($29,900).
Ashbaugh & Allard	1984	Pennhurst State (ICF-MR) institution and community living arrangements (CLAs) with 3-6 residents in Pennsylvania	Residential, day programs, case management, specialized support services, medical and transportation	Costs of components calculated for individuals in both CLA and Pennhurst	Average annual costs for persons in CLAs ($33,250) less than in Pennhurst ($44,900) or average for PA state institutions. Wider range in client costs in CLAs ($7,200 to $92,200) than in Pennhurst ($36,400 to $76,250).
Campbell & Smith	1986	All large public institutions and all community facilities (1-8 res., 9-16 res.) in South Dakota	Residential, day programs, case management, administration, medical services, follow-along services for each individual. All other costs prorated to each individual in each type of facility	Actual costs computed for individuals in institutions and community settings, except for "other" which included all other costs for each category of facility (e.g., training, monitoring) equally apportioned to each resident of the facility type	Average annual institution costs of $30,536 were higher than $16,893 in community settings. Controlling for 4 levels of resident service need (of 9 total) with at least 40 institution and 40 community residents, community costs averaged 71% of institution costs

While the set of controlled cost studies in staffed community-based facilities and public institutions is limited in size, it represents a more systematic data base on costs than exists among the different models of community based care. A substantial number of studies gathered statistics on the daily reimbursed costs in different community settings. For example, Baker, Seltzer, and Seltzer (1977) found that small group homes serving 6-10 residents in 1973 were considerably more costly ($5,700 per resident per year) than larger group homes of 11-20 residents ($4,100) and facilities for 21-40 residents ($3,400), and that all were considerably more costly than generally smaller family care programs ($2,200). Intagliata, Willer, and Cooley (1979) found that annual per capita costs for family care was $3,130 compared to $9,255-$11,000 for group homes. The limitations of these studies and others which have compared different models of community care has been their lack of careful accounting of specific cost components. In defense of the somewhat less rigorous controlling of all costs included in facility reimbursement rates, particularly in the small community facilities, those rates almost always exclude the day programs, which constitute the most costly nonresidential service and are contained in the reported per diem expenditures of less than 5% of programs with 6 or fewer residents (Lakin, Hill, & Bruininks, 1985).

Anderson et al's (1987) study of a 10% sample of facilities with one or more persons aged 63 or older with mental retardation found dramatic differences in per diem reimbursements. Average resident per diems collected in 1985-6 were $14.30 for foster care, $31.70 for group homes of up to 15 persons, and $35.10 for large private facilities with 16 or more residents. Nationally, a 1982 survey of residential facilities found the average daily per resident cost of 18,000 family care settings was $16.15 for Fiscal Year 1982, as compared with $41.22 for nearly 16,000 group homes of 6 or fewer residents and $36.60 for group homes of 7-15 residents (Lakin, Hill, & Bruininks, 1985). These differences accrued despite general comparability in the residents of the two types of facility (36.4% versus 37.8% being severely or profoundly retarded, 9.3% versus 7.4% being nonambulatory, 13.1% versus 9.4% not being toilet trained). The differences noted among the two types of facilities in the functional skills of their residents may have related in large measure to the greater proportions of young children in family

care. In comparing the models, staffed facilities tend to engage greater numbers of care providers in residential programs and do so in a more scheduled and systematic way, but when comparison is made of the number of nonhandicapped adults on site per resident at a particular time, family care homes show themselves to be well staffed. For example, on a typical weekday evening at 7:30 p.m., family care providers report 1.8 residents per nonhandicapped adult in the home; the average for small group homes (6 or fewer residents) was reported to be 2.8 residents per staff member in the home. Both of these resident-to-staff ratios compared favorably with group homes of 7-15 residents (4.9 residents per staff member) and very favorably with public institutions (7.1 residents per staff member) and private institutions (7.7 residents per staff member). Such comparisons accentuate consideration of costs not just in terms of total dollar amounts but also the level of supervision purchased with those expenditures. In those terms the already substantial differences in the cost of family care and small group care facilities might be increased further. On the other hand, if one were to compare hours of structured training purchased with the average daily facility reimbursement, a different comparative picture might emerge. Such analyses would be based on the assumption, not frequently made in cost studies of residential services, that the "products" of the residential care system can, and perhaps should, be seen as something more than a day of "care." Among the numerous other potential products which could be considered are amounts of training, recreational activities, experiences in the community, and so forth.

In looking specifically at family care models, it is clear that among the benefits of considerable merit that have been noted (e.g., normalized living environments, friendships in the neighborhood of residence), relatively low cost is clearly another important aspect. Two factors stand out in the universally observed lower costs of the family care model. The first and major factor is the cost of staffing. It is simply much less expensive to offer a fee for a qualified foster care provider than to pay wages to the usual number of persons who are needed to staff a small group home. The second factor is that capital costs are virtually eliminated from the costs of family care. Family care is provided in the "facility" that serves as the provider's primary domicile, utilizing furniture, appliances, means of

transportation that are already or would otherwise generally be required for the household. As such the reimbursements offered can generally *use* rather than *purchase* the essential capital equipment of residential care.

Small group home care, on the other hand, generally incurs many of the same costs required of institutional care, and, therefore, per resident costs incurred are generally similar for similar components of care. Such similarities became further heightened when facilities operate under the same set of standards, especially those which govern participation in the ICF-MR program. ICF-MR regulations, although providing some flexibility in the ability of small ICF-MR facilities to contract for services not provided by professionals on-staff, nonetheless stimulate a detailed set of specific services that must be available to residents, ranging from standard medical/dental to the services of a nutritionist in planning menus. The regulations also specify minimum staffing patterns for diagnostic groups of residents and require that facilities provide programs of active treatment (see Boggs, Lakin, & Clauser, 1985 for details). Not surprisingly, then, small ICF-MR group facilities are considerably more costly than non-certified group facilities. For example, noncertified private small group homes in 1982 had an average cost per day of $25.33, while private ICF-MR group homes averaged $62.19 per day. Indeed, among all types of facilities in the United States in 1982, ICF-MR certification was the single most important factor in accounting for facility costs in cost function analysis (Greenberg, Lakin, Hill, Bruininks, & Hauber, 1985). Regarding this finding, the authors concluded that controlling for case-mix, other facility characteristics, and state, ICF-MRs were on the average almost $24.00 per day more expensive than non-ICF-MRs. They then ask, "What is the extra $24 a day purchasing? To what extent do these additional expenditures translate into higher quality of care? Are these additional expenditures necessary and/or beneficial to all groups of residents? . . . [S]uch considerations will ultimately be determined by better understanding the services that are purchased with these expenditures" (p. 7.69). Because small ICF-MR group homes are such a notable subset of small group homes in terms of their costs, and presumably, but possibly not, in what they provide for those extra costs, the small group home sample in this study was controlled to include small ICF-MR group homes.

Purpose of This Study

The preceding pages provided a review of research and issues guiding the present study. The purpose of this study was to conduct a comprehensive examination of family care and small group care by gathering detailed information on a wide range of topics that previous research and the philosophical and habilitative principles outlined earlier in this chapter suggest as important to the further development of small, community-based living arrangements for persons with mental retardation. The study examined and compared foster homes and small group homes providing community care to persons with mental retardation by describing the nature and variations in residential services provided in small staffed and specialized family care residential placements. Specific attention was given to issues such as:

- the characteristics of residents, including primary and secondary disabilities, functional skills, challenging behavior, special health/physical needs, and so forth,
- the characteristics of facilities, including licensing, accreditation, certification, administration staffing, location, and so forth,
- the characteristics, training and attitudes of primary care providers,
- the amount and nature of services and care received by residents,
- the amounts and types of habilitation/training activity provided,
- the leisure and recreational experiences, social contacts and community integration of residents,
- the amount and quality of contact with family, friends, and non-handicapped people in general,
- the opportunities for improving and practicing independent living/community utilization skills,
- the elements of cost reflected in reimbursement, including differential rates of reimbursement, non-reimbursed costs such as volunteered capital expenses (e.g., house, car), and costs not reflected in reimbursement that are provided through other agencies (e.g., sheltered workshops, recreational programs).

Research Questions

The research questions of this study included those areas considered essential to an assessment of the status and potential of small groups and family care programs in the United States. Among those areas and the related research questions were the following:

- *Characteristics of Clients*: How do the specific functional characteristics of residents of specialized family care compare with those of small group care? What are medical and health needs, special habilitation needs, and other service needs? What assistance do providers receive and feel they need in dealing with various resident characteristics?

- *Programs and Services*: What programs and services do residents receive, and how often are they provided? How do the programs and services received by residents in specialized family care homes compare with those of residents of small group facilities? What programs and services are needed? Are mandated programs (e.g., education for children) delivered?

- *Daily Activities*: What kinds of social, leisure, recreational and other daily activities do residents engage in? How do those family care residents compare with the residents of small group facilities? Are certain types of activities clearly missing from the lives of residents?

- *Community Participation*: How do the opportunities for independent activity and community participation in family care homes compare with small group residences when controlling for client age and level of impairment? How actively do care providers support integration of residents?

- *Characteristics of Caretakers*: What are the characteristics of family care providers and how do these differ from those of small residence staff (e.g., demographic, education, training, experience, attitudes, goals for residents, stability as care providers, activities with residents)? What do care providers themselves see as their own greatest needs? What do care providers see as the most important factors affecting the growth and success of family care and small group care programs? What types of residents would providers specifically desire/be willing to work with? What types do they feel are most appropriate for family care?

- *Family and Friendships*: What kinds and frequencies of family involvement is maintained for residents of family care and small group facilities? What kinds of friendships are maintained with residents and with whom? What is done to promote family involvement and friendships?

- *Cost of Care*: How do cost and reimbursement rates of family care and small group care homes compare? What factors account for differences (e.g., payroll, capital expense)? What services do these costs purchase and at what cost-to-service ratios? Do differences suggest cost-benefit based policies for state and federal governments?

- *Recommendations*: Based on study findings, what particular factors stand out as important as states utilize family care and small group care facilities in continuing the evolution of community-based services systems? What are the positive and negative aspects of each model? What are the important problems that must be addressed in improving the quality of each of the model?

CHAPTER 2

METHOD

This study was based on a three-stage sample of small foster homes and staffed group homes in the United States and of residents in them. For the purposes of this study, "small" was defined as 6 or fewer residents, not including foster parents or staff. The first stage of sampling was development of a sample frame through a national census of residential facilities (Hauber et al., 1984). The second stage of sampling was the selection of a controlled random sample of facilities from six type-by-size groups, including foster homes, small group homes, and small ICF-MR certified group homes (ICFs-MR), with each type divided into facilities with 4 or fewer residents and those with 5 or 6 residents. The third stage of sampling was the random selection of individual residents within the sampled facilities. Data collection for both the facility sample and the resident sample was carried out through a combination of telephone interviews and mail questionnaires.

Sample Frame

The sample frame for this study was a national registry of all family care and group care facilities that were licensed, contracted, or operated by states (as of June 30, 1982) to provide residential services to persons with mental retardation, and which had 6 or fewer residents, one or more of whom had mental retardation. The sample frame was developed by the Center for Residential and Community Services (CRCS) in its 1982 National Census of Mental Retardation Facilities, which was carried out in the last 3 months of 1982 and the first 6 months of 1983. In all, the 1982 census identified 15,663 facilities providing 24-hour, 7 days-a-week responsibility for room, board, and supervision for one or more persons with mental retardation. Data gathered on facilities in the registry included basic administrative and resident data, resident movement data, cost, and personnel data (Hauber et al., 1984). Respondents to the 1982 census classified their own facilities according to several operational definitions of facility types, two of which were:

- A residence owned or rented by a family as their own home, with one or more mentally retarded people living as family members (e.g., foster home)

A residence with staff who provide care, supervision, and training of one or more mentally retarded people (e.g., group residence)

The registry of facilities from the 1982 census represented a unique universe from which to draw the nationally representative sample of the facilities of interest in this study. Analysis of this registry showed foster homes and small group homes to be the two most numerous types of residential facilities nationally. Specifically the analyses showed that among 15,633 facilities with 243,669 residents there were 6,587 foster homes (with 17,147 residents with mental retardation), and 3,557 small ICF-MR and non-ICF-MR group residences (housing 15,701 residents with mental retardation). In all 10,144 facilities nationwide (64.9% of all facilities) were in the type and size categories being studied and 9,932 of these (97.7%) had all facility, resident and contact data needed to be included in the sample frame. Of these facilities, 64.2% were foster homes (with 49.9% of residents), 30.9% were non-certified group homes (42.0% of residents), and 5.0% were ICFs-MR (8.1% of residents).

In order to accomplish the sampling process the sample frame was stratified into the six size-by-type groups noted above. The distribution of the facilities in the sample frame and the total number of persons with mental retardation in them is shown in Table 2.1.

Table 2.1

Distribution of Facilities and Residents
in the Sample Frame

Group	Total Facilities Nationally	MR Residents Nationally
Foster homes[1]		
4 or fewer residents	5,426	10,794
5 or 6 residents	949	4,885
Group homes		
4 or fewer residents	1,521	4,610
5 or 6 residents	1,544	8,562
ICF-MR Group Homes		
4 or fewer residents	146	500
5 or 6 residents	346	2,029

[1] This number differs from the total number of foster care homes and residents reported above for two reasons. First some facilities identified as "foster care homes" had more than 6 residents. Second in the 1982 survey, three states surveyed their foster care providers independently and providers were identified only upon their approval. The sample frame did not include providers who requested that they not be identified.

Facility Sample Selection

In designing a sampling strategy, a decision had to be made about whether the primary goal of the sampling process should be to approximate the general distribution of facilities (as shown in Table 2.1) or to sample so as to facilitate description and comparison of facilities in the different categories being studied. Because the purpose of the study was clearly more directed toward describing and comparing the six facility groups than toward developing population estimates, a controlled sampling strategy was devised to provide an adequate sample of each type of facility to permit such descriptions and comparisons. However, equal cells for each facility type were not planned for two reasons. Family care settings with 4 or fewer residents constituted about 55% of the total facilities in the sample, but only about one-third of the total residents of small residential settings in 1982. This suggested that a somewhat larger sample of these facilities would be appropriate in order to obtain an adequate sample of residents in the second stage sampling. In stage two, two residents were sampled from each facility, with the obvious exception of the foster homes with only one resident. From the sample frame data it was expected that approximately 40% of sampled foster homes in the 1-4 resident category would have only one resident. Therefore, increasing the sample size of the smallest foster homes (1-4 residents) would be necessary to ensure a comparable number of residents of these homes in the sample. It was also observed that the two small ICF-MR cells had relatively few facilities and that these facilities were concentrated in three states (New York, Michigan, and Minnesota). Therefore, it was believed that the sample sizes for these facilities could be reduced somewhat below those of the other facility types. With these considerations the sample of facilities and residents shown in Table 2.2 was planned.

The sample frame for this study contained information on facility type and size, address, phone number, and the name of the census survey respondent. For each of the six type-by-size groups a complete listing of facilities was printed, grouped by state. The total desired sample size was then divided by the total number of facilities in each type-by-size sample frame to obtain the sampling ratio. A random number was selected from 1 to the denominator of the sample ratio. Beginning with the

Table 2.2

Desired Sample of Facilities and Residents

	Number of Facilities	Number of Residents
Foster Homes		
4 or fewer residents	60	80
5 or 6 residents	40	80
Group Homes		
4 or fewer residents	40	80
5 or 6 residents	40	80
ICF-MR Group Homes		
4 or fewer residents	20	40
5 or 6 residents	20	40
Total	220	400

facility with that number and continuing through the sample frame, facilities were selected at intervals equal to the sampling ratio.

The sampling of facilities for this survey occurred in June 1986. This meant that on the average, approximately 3 years had elapsed from the time the census questionnaire had been returned. A considerable amount of change was discovered among the facilities and respondents during this period. Four basic types of change were noted: 1) facility closure, 2) facility movement to an unknown address, 3) change in facility size and/or program type, and 4) change in the facility staff. Because of these instabilities certain rules were established to govern facility eligibility for participation in this study:

1. If a facility changed address since completing the 1982 questionnaire and could be located, it was included in this study if the same provider had moved the facility with at least one of the original residents, *and* the facility still met the criteria of inclusion *and* the following conditions were met.

2. If a home of a particular type had changed size between June 30, 1982 and the time it was recontacted, moving from the smaller (1-4 residents) to the larger (5 or 6 residents) category, or vice versa, it was included in its new size category. If it had grown to larger than 6 residents or no longer had residents with mental retardation it was replaced.

3. If a facility indicated that it had changed type, either from family care, group care, or ICF-MR to some other type, it was replaced.

4. To participate in the study, a group home had to have available for participation an individual who worked at least 50% time (FTE) in the facility and at least 25% time in a direct-care role, and who had worked in the direct-care capacity for at least three months.

Facilities which were no longer eligible because of size or type changes or because they had no eligible direct-care respondent, facilities which could not be located, and facilities which refused to participate were replaced with the facility appearing immediately after it in the sample frame listing.

Response Rate

Table 2.3 shows details of the original sample of facilities and residents, participants from the original sampling, replacements, nonparticipants, and the final number of responding facilities and residents. As shown, a substantial number of facilities sampled or among replacements (73) did not meet the inclusion criteria for this study. Although the proportion of ineligible facilities was fairly similar across facility types (from 25% to 45%), the reasons for ineligibility varied by type and size groupings. Population increases giving facilities more than 6 residents were common, particularly in the 5 to 6 resident sample frame grouping. Often this reflected the fact that the facilities surveyed in 1982 were new and although they had 6 or fewer residents on the date of the 1982 survey, they were in the process of increasing their resident population, so that by the time they were recontacted for this study their number of residents was higher than the study's upper limit of 6. More often it merely reflected fluctuating populations within facilities serving from 5 to 8 residents. Among the smallest foster care homes it was common that facilities no longer had a resident with mental retardation. These homes were also the most likely to have changed address. Changing facility "types" also occurred at times, with changes from foster home to group home or from noncertified group home to ICF-MR group home occurring fairly frequently. Particularly among facilities that in 1982 had reported themselves to be foster homes of 5 and 6 residents there was a tendency to redefine themselves as group homes. Among facilities that in 1982 had indicated themselves to be group homes of 4 or fewer residents there was a tendency to redefine themselves as family care homes. In both instances facilities were then considered ineligible and were replaced.

Despite the higher than expected noneligibility and the "unknown" status among small foster homes, which appear to demonstrate a rate of mobility similar to households in the general population, no obvious biases were apparent in the sample. Facilities that moved or closed are discussed in detail

Table 2.3

Desired and Obtained Samples and Categories of Nonparticipants in the Study

Facility Types	Initial Sample		Initial Facility Participants	Replacement Facility Participants	Nonparticipants by Reason[a]			Final Responding	
	Facilities	Residents			Not Eligible	Unknown	Refused	Facilities	Residents
Foster Homes									
4 or fewer residents	60	80	26	19	16	12	6	45	71
5 or 6 residents	40	80	15	20	15	3	7	35	68
Group Homes									
4 or fewer residents	40	80	21	7	13	1	5	28	53
5 or 6 residents	40	80	17	22	18	2	3	39	77
ICF-MR Group Homes									
4 or fewer residents	20	40	11	5	6	0	3	16	32
5 or 6 residents	20	40	11	7	5	0	4	18	35
Total	220	400	101	80	73	18	28	181	336

[a]In cases when a replacement selection was itself unknown, not eligible, or refused to participate, it was replaced again. Therefore the total number of nonparticipants is greater than 100%.

in Hill, Chen, Bruininks, & Matteson (1988).[1] Refusals were modest in number, particularly given the extensive demands the study placed on respondents. Refusals numbered 28 in all and were proportionally distributed across all facility types. Refusals as a percentage of total facility participants plus refusals were 13.4% for all facilities and ranged from 7% to 18% among the six facility groups.

In all, 38 states had one or more facilities selected for participation in this study. Facilities from 37 states actually participated. On June 30, 1982 the 13 states from which no facilities were sampled accounted for 2.5% of the total number of facilities in the United States with 6 or fewer residents. With respect to the states from which facilities were sampled, California had the greatest number of participating facilities (41), followed by New York (21) and Michigan (19). Together these three states accounted for 45% of the facilities in the sample as compared with 48% of the total number of facilities with 6 or fewer residents in the sample frame. Based upon the sample characteristics, it is reasonable to conclude that the sample quite closely approximates the distribution of such facilities in the United States.

Questionnaire Development and Field Testing

Data collection instruments were developed around a base of specific research questions raised in previous research and/or intuitively related to efforts to provide residential services that reflect evolving standards for community-based services. Assistance in the development and review of instruments was obtained from a number of colleagues, including James Intagliata who in collaboration with Barry Willer had previously conducted a number of important studies of foster care and small group facilities (a number of which are referred to in Chapter 1). Survey instruments were drafted, reviewed and revised, then field-tested with eight foster care and small group care providers, and revised a final time.

Most questionnaires, other than the facility interview survey, were completed by mail. However, all respondents were given the option of a full telephone interview for all survey instruments. It was assumed that this would reduce the likelihood that careproviders with relatively low reading and writing

[1]Follow-up on homes that had moved indicated that in many cases residents moved with the facility.

abilities and/or low English proficiency would have a higher tendency not to respond. The study was conducted in "waves" beginning in September 1986 and continuing until March 1987. Each wave was approximately 2 months long and permitted concentrated assistance and follow-up to be directed to the approximately 50 respondents being surveyed during each wave.

Respondent and Subject Identification

Facilities were first contacted by an introductory letter which contained an explanation of the project, the expectations, availability of a modest payment for participation, and information about the schedule of the subsequent phone contact. The letter and an initial phone contact were directed to the respondent of the earlier 1982 census survey. Frequently that individual was no longer at the facility, or was there, but in a capacity that did not make him/her an eligible respondent. In such instances another eligible respondent was identified. Criteria for eligibility as a respondent included working at least 50% time, including at least 25% time as a direct-care provider and having worked in a direct-care capacity for at least three months. For the purposes of this study, a direct-care staff member was considered to be the person, or one of the persons with primary responsibility for the day-to-day care and supervision of the facility's residents. No specific methods were employed to identify any particular respondent in those facilities in which more than one qualified respondent was employed. Generally in eligible facilities the respondent was the first eligible individual contacted in that facility. In order to maximize participation, a twenty-five dollar honorarium was offered to eligible respondents at the time of initial contact for what was estimated to be three to five hours of total time commitment over the course of the project.

In the original telephone contact, respondents were identified and a brief interview was conducted or scheduled. The telephone interview had four purposes: 1) to determine eligibility of facilities; 2) to identify and obtain a commitment from an eligible direct care person to serve as a respondent; 3) to orient respondents to the study in general and to the specific questionnaire packets that would follow; and 4) to gather facility data that would be difficult to obtain in the mail questionnaire. Usually, too, during this contact the specific subjects of the resident questionnaire were identified using

a "resident identification worksheet." Whether mailed or administered over the phone the purpose and procedure of the resident identification process was the same: to identify facility residents eligible for the resident sample and to implement a procedure for the random selection of sample members from among eligible residents. In order to be eligible for sampling, a resident must have been classified as mentally retarded and must have lived in the home for at least 3 months. If it was determined at the time of the original phone interview that a facility had only one or two eligible residents, it was agreed that the individual or the pair would automatically become subjects of the study. In cases where facilities had 3 to 6 residents, the resident identification procedure was a straightforward way to systematize a simple selection strategy. Using first and last initials of all facility residents, the two individuals selected were the first two in alphabetical order according to those two letters. These initials then further served as identifiers for the resident questionnaires, and during editing and follow-up. The facility interview conducted at this time, usually supplemented with additional follow-up interviews, gathered considerable general information on facilities and their residents as well as detailed information on facility costs and administration. Mail questionnaire packets, which followed within a week of the telephone interview, had two or three primary inserts. These were 1) a resident identification worksheet (if not completed over the telephone), 2) a careprovider questionnaire, and 3) one or two resident questionnaires. The careprovider questionnaire was designed to gather basic information about the careproviders' demographic characteristics, training, attitudes, and job relevant characteristics. This questionnaire was completed by the direct care respondent regarding him/herself. The resident questionnaire (one or two per home) focused on gathering a comprehensive set of data on the characteristics of residents as well as on the services, programs, community and leisure activities and other experiences and opportunities that define the nature and quality of their life in the community.

Editing, Coding and Data Processing

When questionnaires were received they were immediately logged, checked to see that the return contained all questionnaires that had been mailed to respondents, and, within a day or two

edited for completeness and logic of responses. Callback interviews were necessary for almost all questionnaires, as anticipated prior to the study.

A codebook for coding responses was developed by 5 staff members jointly coding 20 completed questionnaires. All further coding then complied with the standards and rules established in the codebook. All coding was done by one of 5 staff members directly involved in product instrumentation and data collection. Periodic independent check coding was also employed to monitor coding accuracy. Overall, more than 25% of questionnaires were check coded with no evidence of significant errors. Certain open-ended item codes were 100% check coded.

Following data entry, extensive computer checks were conducted to detect errors of coding or to question inconsistent responses to survey questions. These last editing problems were rectified through correcting errors, or in the case of illogical, erroneous, or otherwise questionable responses, through a final follow-up to respondents or by coding data as missing. Decisions with respect to further follow-up or coding data as missing were based on the relative importance of the data in question.

Special Analysis of Community Integration

A subset of items pertinent to integration or potentially associated with community integration were selected from the survey for a special analysis described fully in Chapter 6 of this report. The same items were adapted slightly and administered to a random sample of the United States population (N = 100). "Integration into the life of the community" was defined as consisting of four components: (a) domestic, (b) vocational, (c) leisure, and (d) social integration. A multivariate analysis of variance was used to compare the four groups of individuals (foster home, group home, and ICF-MR certified group home residents, and the general population) on the four-variable integration construct. Canonical correlation for the four-variable integration construct and multiple regression (for analysis of each of the four components) analyses were undertaken to determine factors associated with integration for people in residential facilities.

CHAPTER 3

FACILITY AND CAREPROVIDER CHARACTERISTICS

This chapter presents information about a range of physical and administrative characteristics of sampled facilities and their staff.

Facility Characteristics

Table 3.1 reports basic descriptive statistics about the residential facility samples by facility type and size. As would be expected, licensed capacity and average number of residents per facility are closely linked. The only notable difference in average size was among the small facilities (4 or fewer residents). Small foster homes averaged about 2.2 residents, small group homes 3.2 residents and small ICFs-MR 3.9 residents. Small ICFs-MR averaged almost exactly 4 residents because by regulation an ICF-MR cannot be smaller than 4 beds. Openings within these facilities permitted the average to fall below 4 residents, just as openings caused some ICFs-MR licensed for more than four residents to fall into the category of 4 resident facilities at the time of this survey.

Licensed capacity and current resident population statistics indicate that all but small foster homes were operating at very close to licensed capacity. Among the small foster care homes the resident population was only 66% of the licensed capacity. Presumably most of these foster homes do not intend nor desire to operate at the formal maximum capacity established for them by licensing. Occupancy rates for the other types of facilities ranged from 92% in large group homes to 98% in large ICFs-MR.

Residents with mental retardation. Residents in all groups of facilities were overwhelmingly persons with mental retardation. Persons with mental retardation made up 98% of more of the resident populations of all facilities except the larger group homes in which 93% of residents were persons with mental retardation.

Staffing pattern. Small residential facilities frequently use staffing patterns in which careproviders live in the facility along with the residents. Foster care settings are by definition and in actual practice "facilities" in which persons with mental retardation live in the home of their primary care

Table 3.1

Selected Administrative Characteristics of Small Residential Settings for Persons with Mental Retardation

Administrative Characteristic	Facility Type / Residents						
	Foster Home		Group Home		ICF-MR		
	1-4 (N=45)	5-6 (N=35)	1-4 (N=28)	5-6 (N=39)	1-4 (N=16)	5-6 (N=18)	F/X^2
Licensed Capacity							
M	3.39	5.85	3.52	6.16	4.13	5.89	51.5**
SD	1.70	.44	.77	.76	.50	.47	
Total number of Residents							
M	2.24	5.63	3.25	5.64	3.94	5.78	126.9**
SD	1.15	.49	.58	.87	.25	.43	
Number of Residents w/ MR							
M	2.20	5.23	3.18	5.62	3.94	5.78	90.7**
SD	1.12	1.14	.61	.88	.25	.43	
Staffing Pattern							
Shift only	0.0%	0.0%	71.4%	61.5%	75.0%	77.8%	92.2**
Live in	100.0	100.0	28.6	38.5	25.0	22.2	
Household size[a]							
M	5.07	8.06	3.71	6.31	4.25	6.06	36.8**
SD	1.98	1.33	1.18	1.32	.68	.80	
Operating Agency							
State/PRF	0.0%	0.0%	3.7%	2.6%	0.0%	0.0%	166.6**
Regional/Local Gov	0.0	0.0	7.4	10.3	0.0	0.0	
Priv for Profit/Family	100.0	100.0	11.1	10.3	0.0	5.6	
Private Nonprofit	0.0	0.0	77.8	76.9	100.0	94.4	
Other	0.0	0.0	0.0	0.0	0.0	0.0	
Restricted from Admission							
Children/ Adolescent	38.6%	40.0%	64.3%	76.3%	53.3%	72.2%	18.1**
Adults	25.0	25.7	7.1	7.9	6.7	0.0	13.7*
Males or females	36.4	22.9	17.9	31.6	33.3	22.2	4.2
Persons not toilet trained	47.7	31.4	14.3	31.6	6.7	16.7	15.6**
Persons using wheelchairs	54.5	37.1	17.9	31.6	33.3	33.3	10.9
Persons with serious behavior problems	56.8	45.7	3.6	18.4	6.7	22.2	35.1**
Persons who are deaf	27.3	25.7	0.0	13.2	0.0	5.6	17.1**
Persons who are blind	38.6	31.4	0.0	26.3	0.0	16.7	20.9**
Persons needing daily medical procedures	27.3	11.4	3.6	10.5	0.0	0.0	16.4**
Persons with epilepsy	29.5	14.3	0.0	2.6	0.0	0.0	26.8**
Persons needing special diet	13.6	17.1	0.0	2.6	0.0	0.0	13.6*
Persons tending to run away	47.7	45.7	3.6	18.4	6.7	0.0	35.7**

[a] Household size includes residents and live-in staff.

* $p < .05$
** $p < .01$

providers. In group homes and ICFs-MR, careproviders "live-in" in only about 30% of facilities. Group homes were somewhat more likely than ICFs-MR to have live-in careproviders. (Note that in this study, facility size was based only on the number of residents with handicaps.)

Household size. When one includes all members of the household (persons with mental retardation, live-in care providers and their families), the average household size of foster homes is considerably larger than the group and ICF-MR facilities of the same size category (i.e., 1-4 residents, 5-6 residents). Most people living in the smaller foster care homes were in households where a minority (44%) of household members were disabled. Households in the larger foster care homes were about 70% composed of persons with all types of disability and 65% persons with mental retardation. Group home and ICF-MR households were predominantly composed of persons with disabilities, averaging 88% to 95%. Half of all foster homes and 5% of the group facilities had children of careproviders living in the facility.

Operating agency. By definition, foster homes operate like private for-profit agencies, keeping any payments beyond their total costs. In reality, of course, the "profit margin" is minimal to nonexistent. Other small facilities in the sample were overwhelmingly operated by private nonprofit agencies, with about 12% of the smaller and larger group homes operated by state, regional or local government agencies. Among nonfoster care settings, less than 10% of facilities were operated by for-profit agencies or individuals.

Policies and Attitudes Toward Residents

Careproviders were shown a list of characteristics, and asked whether they would consider accepting people with these characteristics for residential placement. Table 3.1 shows the proportion of careproviders who reported they would not consider individuals with various characteristics for admission. Overall, foster parents most often reported restrictions, ranging from a high of 57% of small foster homes that would exclude persons with serious behavior problems to a low of less than 15% of foster homes that would place limits on daily medical care or special diets. Foster homes were less likely than group homes or ICF-MR certified group homes to exclude children and more likely to exclude

adults. These "preferences" were of course related to licensing. Approximately one third of all facilities accepted only males or only females.

In a follow-up open-ended question, the most commonly stated reasons for restrictions on admissions were that the home was not staffed, trained or able to handle the work required by residents with certain characteristics, indicated by 18-43% of respondents depending on facility type; personal preference, indicated by 8-46% of respondents; conflict with the characteristics or needs of other residents, indicated by 12-27% of respondents; or certain resident characteristics that would require physical modifications to the home. Careprovider's age, health and/or strength were occasionally mentioned by foster care providers as a reason (18% and 17% of small and large foster care facilities respectively) but never by other careproviders (who tended to be much younger on the average). Licensing requirements were mentioned by less than 20% of respondents as a reason for restrictions on admission, and financial reasons, including the need for more or different insurance, were cited by less than 10%.

Respondents in 60% of facilities surveyed indicated that their facility had in the past accepted at least one resident whose placement had not worked out. There were no significant differences between facilities in the incidence of unsuccessful placements nor in how long ago the most recent one occurred (50% within the last 5 years). When asked about the disposition of these residents, 41% of careproviders did not know where the (most recent) resident went after leaving, 18% indicated that he or she had gone to a state institution, 10% to another group home or foster home and 8% to live with their parents or relatives. Seventy-five percent of unsuccessful placements were reported to have been related at least partially to a behavior problem.

Respondents were asked whether calls and visits from residents' family members affected the success of residents' placement in their home. Overall, almost no respondents (4%) felt that contact with family members hindered the success of placements. The majority (58% overall) felt that the amount of family contact that benefitted the community placements depended upon the particular resident, while another 21% felt that the amount of family contact was directly related to greater

placement success; 11% indicated that family members did not have any contact with the residents under study.

Resident involvement in decision making in the home. Overall, a slight majority of respondents (58%) indicated that residents made their own decisions about what to wear each day. The decision was mutual (resident and careprovider) in 24% of homes, and the careprovider made the selection in 10% of all homes. Decisions about room decoration were made by the residents themselves in 40% of facilities, mutually in 45%, and by the careprovider in 15%. Although facility differences were found in the manner of roommate selection, these were largely attributable to the fact that nearly half of residents in small foster care and small group homes did not share rooms (42% and 48% respectively), compared with 6-9% in other facility types. Residents selected roommates themselves in 4-18% of facilities depending on the type; careproviders alone made the decision in 13-24% of facilities, it was mutual in 7-22% of facilities surveyed, other factors determined the decision 15-20% of the time (e.g., clients were assigned to "empty beds"), and careproviders made the decision, but took many factors into account, in 7-22% of the facilities.

Most careproviders indicated that residents' hours were individualized, with 69-87% (depending on the facility type) indicating that some residents could stay up later than others. Most respondents also indicated that some residents could get up earlier than other residents or careproviders. Most, however, did not allow residents to stay up later than careproviders at night, or indicated that some staff were awake around the clock. Only 13-39% of respondents stated that residents were permitted to stay up after the careprovider had gone to bed.

Open-ended responses from almost all respondents (92-100%) indicated that they enjoyed social activities with residents together as a family. In addition, 80-94% indicated that they ate meals together as a family. A minority of respondents (16-39%, depending upon facility type) felt that having mentally retarded individuals in the home had discouraged neighbors from visiting.

Licensing and Monitoring

Table 3.2 summarizes the findings on licensing and monitoring of the community facilities. All residential programs in the sample reported having a specific license to operate their program. The vast

majority (89%) of the facilities in this sample reported that they received their license or certification from a state agency. Regional agencies of the state or local (county) governments licensed about 5% of facilities. None of the facilities reported themselves to be licensed by private agencies functioning as quasi-public representative of government agencies. Careproviders in about 8% of all facilities (23% of group homes) were unsure of the specific agency that provided their license to operate a program.

Only 9% of facilities in the sample reported they were visited by their licensing agency less than once per year. Less than annual visits were most often reported by the smaller foster homes

Table 3.2

Licensing and Monitoring of Small Residential Settings for Persons with Mental Retardation

Facilities	Facility Type / Residents						x^2
	Foster Home		Group Home		ICF-MR		
	1-4 (N=45)	5-6 (N=35)	1-4 (N=28)	5-6 (N=39)	1-4 (N=16)	5-6 (N=18)	
Licensed/Certified by:							
State Agency	94.4%	100.0%	77.8%	66.7%	100.0%	88.9%	27.2*
Regional/Local Gov	5.6	0.0	7.4	5.1	0.0	11.1	
Private	0.0	0.0	0.0	0.0	0.0	0.0	
Not Sure	0.0	0.0	14.8	28.2	0.0	0.0	
None	0.0	0.0	0.0	0.0	0.0	0.0	
Licensor Visits per Year							
Less than 1	19.0%	0.0%	11.5%	7.7%	0.0%	0.0%	31.9*
One	69.0	92.3	88.5	61.5	71.4	76.5	
Two	7.1	0.0	0.0	23.1	28.6	11.8	
Three	2.4	3.8	0.0	3.8	0.0	5.9	
Four	2.4	3.8	0.0	3.8	0.0	5.9	

* $P < .01$

(19%) and the smaller group homes (12%). The vast majority of facilities reported one visit per year from the licensing agency (76%). Fifteen percent of facilities reported that they were visited from 2 to 4 times in the past year by a licensing or certifying agency.

Characteristics of the Residence

The small facilities in the present study were predominantly (83%) single household dwellings. Table 3.3 presents statistics on the location and basic physical characteristics of these homes.

Table 3.3

Characteristics of the Residence

	Facility Type / Residents						
	Foster Home		Group Home		ICF-MR		
	1-4 (N=45)	5-6 (N=35)	1-4 (N=28)	5-6 (N=39)	1-4 (N=16)	5-6 (N=18)	F/X^2
Size of Community							
Farm/Rural	34.1%	37.1%	10.7%	5.4%	13.3%	16.7%	32.0**
Town of less than 5,000	22.7	8.6	10.7	10.8	6.7	5.6	
5,000-50,000 Res.	13.6	22.9	21.4	37.8	13.3	33.3	
Suburb/Large City (50,000+ Res.)	29.5	31.4	57.1	45.9	66.7	44.4	
Type of Neighborhood							
Primarily single family	84.1%	80.0%	60.7%	55.3%	46.7%	94.1%	28.4*
Primarily multiple family residence	9.1	5.7	25.0	18.4	26.7	0.0	
Mixed business/res.	6.8	8.6	14.3	23.7	26.7	5.9	
Other	0.0	5.7	0.0	2.6	0.0	0.0	
Type of Home							
Single Family	88.6%	88.6%	71.4%	81.1%	66.7%	94.1%	15.9
Duplex	9.1	8.6	10.7	13.5	20.0	0.0	
Apartment (3+ units)	2.3	2.9	14.3	2.7	6.7	5.9	
Other	0.0	0.0	3.6	2.7	6.7	0.0	
Size of Home							
No. of Bedrooms							
M	4.11	5.20	4.00	4.49	3.13	3.78	8.5**
SD	1.19	1.41	1.36	1.12	.35	.81	
Bedrooms per Resident							
M	.92	.66	1.10	.83	.76	.62	4.6**
SD	.45	.19	.28	.73	.11	.09	
No. of Bathrooms							
M	1.77	2.63	1.86	2.47	1.53	2.33	7.6**
SD	.80	.88	.80	1.01	.52	.69	
Bathrooms per Resident (incl. live-in CP & fam.)							
M	.39	.33	.52	.45	.37	.39	2.0
SD	.21	.09	.21	.45	.13	.10	
Average Age of Home							
M (years)	41.75	23.58	26.53	30.21	36.80	22.60	2.3*
SD	29.13	20.47	25.48	20.58	29.05	25.28	
Modifications to Home Property for Residents							
Personal for Resident							
Required	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	
Not Required	1.90	0.0	10.7	2.2	5.8	5.0	
General Home/Property							
Required	13.4	10.6	3.6	6.8	35.0	10.1	
Not required	11.5	31.8	3.6	18.0	5.8	20.2	
Total	26.8	42.4	21.4	27.0	46.7	35.3	31.8**

* $p < .05$
** $p < .01$

Statistically significant differences existed among the facility types with regard to the size of the community in which they were located. Foster homes were much more likely to be located in rural and small towns of fewer than 5,000 residents (51% versus 20% for other facilities). Conversely, over half (52%) of group homes and ICFs-MR were in cities and suburbs of 50,000 or more residents, compared with only 30% of foster homes. Most facilities were found to be located in neighborhoods primarily made up of single family homes. About 14% of facilities were reported to be in neighborhoods primarily of multiple household dwellings, and another 14% were reported to be in neighborhoods of mixed business and residential.

Size of home. It was expected that facilities categorized by number of residents would tend to differ in the average number of bedrooms and bathrooms. Facilities with 4 or fewer residents averaged 1.8 bathrooms, while those with 5 or 6 residents averaged 2.3 bathrooms. Facilities with 4 or fewer residents averaged 3.9 bedrooms; those with 5 or 6 residents averaged 4.6 bedrooms. However, facilities did not differ in the average number of bedrooms and bathrooms per resident. All facilities combined had an average of .41 bathrooms per person (including live-in staff), and .83 bedrooms. There was a substantially larger number of bedrooms per resident in the small facilities (.91) than in the larger facilities (.71), a tendency noted in all three types of facilities.

Average age of homes. Statistically significant differences ($F[5,117] = 2.31$, $p < .05$) were noted in the average age of houses in the sample (31 years), with small foster care homes being the oldest, averaging 42 years. This difference may be associated with the greater overall average age of foster parents and/or the small towns and rural communities in which the foster homes tended to be located. It was clearly the case that small residential facilities of all types tended to use existing housing stock in typical residential neighborhoods, and to that extent may have been better physically integrated into local neighborhoods than would have been the case had they primarily been newly constructed facilities.

Modifications to facilities. One third of facilities reported having modified their homes to accommodate one or more of their residents with disabilities. Modifications were most common in small

ICFs-MR (47%) and least common in small group homes (21%). Most modifications were reported to be for residents of the facility in general rather than specific individuals (87% versus 13%). Of all modifications, 38% were reported to be specifically required in program standards, and 62% were to accommodate residents, but were not specifically required. ICFs-MR were the most likely to have been required by external agencies to make modifications (24%).

Payments for Care

Table 3.4 presents statistics on the payments made to facilities for the care of individuals in them. Very large differences were evident among facility types in average monthly reimbursements for residential services. Foster care was by far the least well reimbursed residential option. On the

Table 3.4

Reimbursements to Foster Care and Group Care Facilities Per Resident Per Month, 1986

	Facility Type / Residents						
	Foster Home		Group Home		ICF-MR		
	1-4 (N=45)	5-6 (N=35)	1-4 (N=28)	5-6 (N=39)	1-4 (N=16)	5-6 (N=18)	F/X^2
Av. Base Reimbursmnt per Res. per Month							
M	$585.99	$743.23	$1,903.80	$1,286.83	$2,731.82	$2,515.93	35.1*
SD	215.42	237.96	828.93	773.11	1,434.44	1,080.95	
Supplemental Reimbursements							
% Received Supp.	33.3%	31.4%	14.3%	17.9%	37.5%	22.2%	5.5
Ave. Supplement-All Facilities							
M	$17.04	$10.93	$3.02	$10.99	$21.00	$5.39	1.9
SD	28.24	22.87	9.82	21.39	22.29	12.03	
Range of Base Reimb.							
Ave. Total High 10%	$973.33	$1,029.84	$3,406.50	$2,650.09	$5,481.83	$4,572.92	
Ave. Total Low 10%	317.75	383.70	718.75	346.50	1,521.00	1,438.00	
Single Reimb. Rate	62.0%[1]	40.0%	95.8%	85.3%	92.3%	100.0%	39.3*
Variable Reimb. Rates	38.0	60.0	4.2	14.7	7.7	0.0	
(Rate varies by)							
Age	0.0	0.0	0.0	3.7	0.0	0.0	
Behavior Problems	0.0	0.0	0.0	3.7	0.0	0.0	
Personal Care/Health	25.3	42.4	0.0	3.7	7.7	0.0	
Different Funding Source	8.4	14.1	4.2	0.0	0.0	0.0	
Diff. Personal Allow.	0.0	3.5	0.0	3.7	0.0	0.0	
Other	4.2	0.0	0.0	0.0	0.0	0.0	

[1] Excludes 16 foster care homes with only one resident.

* $p < .001$

average, in 1986, foster care homes in the present study received $657 per resident per month ($21.61 per day), compared with approximately $53 per day for group homes and $86 per day for ICF-MR certified group homes.

Only 25% of facilities indicated that they had received any supplemental funding in addition to their base rate for residents of their facility in the previous 12 months. Supplements refer to special allowances (over and above the base reimbursement) to pay for items or services ranging from clothing, respite care, transportation, or activities for residents. Table 3.4 illustrates the monthly average supplement for all facilities of each particular type. Supplements were most commonly reported among foster homes (32.5%). Supplements were reported by 16% of group homes and 23% of ICF-MR facilities. The amount of these supplements, when provided, was generally quite small (ranging from a monthly average of $21.12 in small group homes to $56.00 in small ICFs-MR receiving them). When the total amount of supplements was averaged across all facilities their monthly average was considerably lower: $14.37 for foster homes, $7.66 for group homes, and $12.74 for ICFs-MR. The most common type of supplement was for clothing, reported by 17% of facilities. Average monthly clothing supplements for facilities receiving supplements in the previous year ranged from $16.67 in small group homes to $24.67 in small ICFs-MR. Averages for all facilities ranged from 60¢ per month for small group homes to $7.71 in small ICFs-MR.

Cost variations within facility types were substantial. Comparison of the high 10% of facilities on base reimbursement with the low 10% in each facility category showed foster care to have the least variability. Small group homes had the greatest relative variability. The high 10% of the small group homes had average rates about 5 times the average rates of the lowest 10% of facilities. Among the larger group homes, average rates of the highest 10% were over 7 times the rates of the lowest 10%. The absolute differences in reimbursement to the lowest 10% and highest 10% of smaller and larger ICFs-MR were $3,961 and $3,135 per month respectively.

The reimbursement of group homes and ICFs-MR was reported overwhelmingly to be based on a single facility-wide rate (92% of facilities). In contrast, half of foster homes (excluding those with

only one resident) indicated variable reimbursement rates for their residents. As expected, facilities with more residents were more likely to have persons with different rates of base reimbursement associated with their care. By far the most common factors used for determining variations in rates were personal care and health needs (reported by 68% of facilities that had variable rates).

Careprovider Characteristics

Primary care providers were defined as the direct care provider most familiar with each sampled resident. Table 3.5 presents the major demographic characteristics of careproviders.

Age of primary careproviders. Very notable differences were evident in the ages of sampled foster care providers and the care providers in the group homes and ICFs-MR. Only 10% of the foster parents were 36 years of age or younger, compared to 75% of careproviders in the other types of facilities. Conversely, 48% of primary foster care providers were 57 years of age or older, compared with only 5% of the primary care providers in group homes and ICFs-MR. The average ages of careproviders in small and large foster care settings were almost identical (54 and 53 years, respectively), as were the ages of careproviders in the small and large group homes and small and large ICFs-MR (32, 35, 32 and 31 years, respectively).

Gender. Direct care in community based residential facilities is predominated by females. Excluding homes in which live-in married couples were reported to share the direct care role equally (about 50% of foster homes and 14% of other facilities), about 75% of primary careproviders were reported to be women. In foster homes in which one person was considered the primary careprovider, females were almost always the primary careprovider.

Race/ethnicity. The race/ethnicity of careproviders was generally proportional to the distribution in the nation as a whole. Seventy-eight percent of respondents were white non-Hispanics, 14% black non-Hispanics and 6% were of Hispanic origin. Within the general population, black non-Hispanics make up 12% of the population and Hispanics comprise 7% of the population. There were significant differences among facility types in the race/ethnicity of careproviders. This may have in part reflected the disproportionate use of the different residential models by states with different racial/ethnic

Table 3.5

Demographic Characteristics of Primary Careproviders

	Facility Type / Residents						
	Foster Home		Group Home		ICF-MR		
	1-4 (N=45)	5-6 (N=35)	1-4 (N=28)	5-6 (N=39)	1-4 (N=16)	5-6 (N=18)	F/X^2
Age							
26 yrs or younger	0.0%	0.0%	44.4%	23.7%	35.7%	44.4%	93.6**
27-36 years	11.4	9.1	25.9	44.7	42.9	33.3	
37-46 years	22.7	18.2	18.5	15.8	14.3	11.1	
47-56 years	18.2	33.3	7.4	7.9	0.0	11.1	
57-66 years	25.0	27.3	3.7	7.9	7.1	0.0	
67 yrs or more	22.7	12.1	0.0	0.0	0.0	0.0	
Gender (primary careperson)							
Male	4.5%	2.9	25.0%	28.9%	13.3%	22.2%	48.3**
Female	52.3	45.7	67.9	65.8	80.0	72.2	
Couple-Neither primary	43.2	51.4	7.1	5.3	6.7	5.6	
Race/Ethnicity							
White, Non-Hispanic	67.5%	82.1%	96.3%	76.5%	61.5%	82.4%	23.6
Black, Non-Hispanic	25.0	3.6	3.7	14.7	30.8	11.8	
Hispanic	5.0	14.3	0.0	5.9	7.7	5.9	
Oriental/Asian/PI	2.5	0.0	0.0	0.0	0.0	0.0	
Native American/Alaskan	0.0	0.0	0.0	2.9	0.0	0.0	
Education (highest)							
Grades 1-11	27.3%	29.4%	0.0%	2.6%	6.7%	5.6%	36.1**
High School Grad	29.5	20.6	14.3	21.1	20.0	5.6	
Some Post-Sec.							
Social Work (1)	0.0	0.0	3.9	5.9	20.0	13.9	
(Special) Education (2-3)	3.0	0.0	7.8	3.0	0.0	20.9	
Psych./Counseling (4-7)	0.0	28.7	0.0	5.9	0.0	0.0	
PT/OT/SpT	0.0	0.0	3.9	3.0	0.0	0.0	
Nursing/Health Care	12.1	4.8	0.0	5.9	10.0	0.0	
Other	12.1	4.8	27.3	20.9	10.0	20.9	
Total	27.3	38.2	42.9	44.7	40.0	55.6	
College Graduate							
Social Work	0.0	0.0	0.0	3.2	6.7	0.0	14.3*
(Special) Education	8.0	3.9	7.8	3.2	0.0	5.6	
Psych./Counseling	0.0	3.9	15.6	15.8	6.7	27.7	
PT/OT/SpT	0.0	0.0	0.0	0.0	6.7	0.0	
Nursing/Health Care	2.7	0.0	0.0	0.0	0.0	0.0	
Other	5.3	3.9	19.5	9.5	13.3	0.0	
Total	15.9	11.8	42.9	31.6	33.3	33.3	
Current Post-Secondary Student	2.2%	2.9%	17.9%	23.1%	12.5%	22.2%	
Marital Status							
Married/Marriage like	70.5%	74.3%	46.4%	47.4%	53.3%	50.0%	35.0**
Widowed	11.4	12.1	3.6	2.6	0.0	0.0	
Divorced/Separated	11.4	11.4	7.1	13.7	13.3	22.2	
Never Married	6.8	2.9	42.9	36.3	33.3	27.8	
Average Years of Caregiving	12.2	13.6	4.6	4.6	6.1	4.9	19.6**

* $p < .05$
** $p < .01$

distributions within their populations (e.g., small foster care and ICFs-MR in New York, large foster care in California).

Education. Foster care providers had less formal education, on the average, than did primary careproviders in the other types of community facilities. Three fourths of foster care providers had completed a high school education, compared with more than 95% of primary care providers in the other community facilities. Conversely, 14% of foster care providers and 34% of group home providers were college graduates. Most careproviders who had attended college had studied in human service or in allied medical fields related to their present occupation (social work, special education, psychology, counseling, physical therapy or occupational therapy). About 20% of the group home and ICF-MR providers were currently enrolled in post secondary education, as compared with 2.5% of foster care providers.

Marital status. Seventy-two percent of foster care providers were married or in a stable marriage-like relationship. About 12% of foster care providers were widowed, 11% divorced or separated--only 5% had never married. In contrast, slightly less than half (48%) of the careproviders in the group homes and ICFs-MR were married, and 38% had never been married, which probably reflects the substantial age differences between foster parents and the other care providers.

Average years of caregiving. Foster care providers averaged considerably more years of direct care experience than careproviders in group homes and ICFs-MR (13 years versus 5 years). It is notable that despite the high general rate of staff turnover in community residential facilities, averaging 55% to 75% in most studies (Lakin & Bruininks, 1981), these facilities are able to maintain at least some experienced direct-care staff. However, because the current study sampled the careprovider who best knew the individual resident, the sample is biased toward employees with longer tenure. Put another way the design of this study cannot be considered representative of all careproviders in general in small group homes and ICFs-MR, because it clearly underrepresents persons with shorter periods of tenure.

Paths to Careprovider Role

Table 3.6 presents the responses of sampled careproviders about their motivations for engaging in direct care work and about the ways in which they were recruited. A little over half (54%) of careproviders in community facilities indicated having prior experience with persons with mental retardation. However, prior experience was virtually unrelated to differences in motivation for taking their current position. For example, 6% of persons both with and without prior experience noted the opportunity to contribute to the community as their primary motivation, 19% of the experienced individuals and 21% of the new careproviders noted various economic considerations as their motivation for taking their specific job, 49% of experienced and 50% of inexperienced carepersons noted

Table 3.6

Paths to Becoming a Careprovider (CP)

Primary Reason for Serving as Careproviders (CPs)	Facility Type / Residents						x^2
	Foster Home		Group Home		ICF-MR		
	1-4 (N=45)	5-6 (N=35)	1-4 (N=28)	5-6 (N=39)	1-4 (N=16)	5-6 (N=18)	
CPs with Previous MR Exp							
Contribution to community	0.0%	5.9%	7.1%	5.4%	0.0%	0.0%	24.8**
Financial considerations	11.4	8.8	7.1	10.8	6.7	17.7	
Satisfaction of caring/teaching	27.2	26.5	28.6	27.1	33.3	11.8	
Enjoyment of companionship	0.0	5.9	0.0	8.1	0.0	0.0	
To care for a particular person	6.8	2.9	3.6	0.0	0.0	0.0	
Other	2.3	14.7	10.7	8.1	0.0	11.8	
Total	47.7	64.7	57.1	59.5	40.0	41.2	
CPs without Previous MR Exp.							
Contribution to community	6.8%	3.2%	0.0%	0.0%	6.7%	0.0%	26.4**
Financial considerations	9.1	9.6	7.2	13.5	6.7	11.8	
Satisfaction of caring/teaching	15.9	12.8	32.2	21.6	33.4	41.2	
Enjoyment of companionship	6.8	6.4	0.0	2.7	13.3	0.0	
To care for particular person	9.1	0.0	0.0	0.0	0.0	0.0	
Other	4.6	3.2	3.6	2.7	0.0	5.9	
Total	52.3	35.3	42.9	40.5	60.0	58.8	
Recruitment of CPs							
Media advertisement	15.9%	5.7%	32.1%	21.6%	20.0%	27.8%	25.7**
Recruited by other CP	31.8	42.9	35.7	37.8	53.3	33.3	
Recruited by Soc. Service Agency	18.2	5.7	3.6	2.7	0.0	0.0	
Initiated contact by self	20.5	28.6	7.1	24.3	13.3	22.2	
Other	13.6	17.1	21.4	13.5	13.3	16.7	

* $p < .05$
** $p < .01$

satisfaction with caregiving or teaching as primary motives, 5% of experienced and 8% of inexperienced staff noted the chance to work with people/enjoy companionship as primary motives, and 5% of both groups (in all but one case foster care providers) noted that they had become involved in order to care for one specific individual.

Recruitment of careproviders. Recruitment by other careproviders was the most common primary way people in the careprovider sample found their present jobs (38%). The second most common primary method of rocruitment was provider initiated contact (20%), followed closely by response to an advertisement in the media (19% of the careprovider sample). Direct recruitment by a social service agency was relatively uncommon in all but small foster care facilities. Other primary sources of recruitment were named by 16% of careproviders. The extent to which careproviders considered themselves to be influenced by a combination of different methods of recruitment (e.g., media attention, self-initiation, friends who were careproviders) was not reported.

There were significant differences in the manner in which careproviders were recruited in the different types of facilities. For example, persons in small ICFs-MR were most likely to be recruited by other careproviders (53%), whereas 32-43% of other careproviders reported being recruited by other careproviders. Media advertisements were used to recruit 32% of small group home providers and 20-28% of other group home and ICF-MR primary providers, but were an uncommon recruitment method for foster care (only 16% of providers in small foster homes and 6% in large foster homes reported this method of recruitment). Small foster home providers were the only providers who reported themselves to be recruited by social service agencies in any sizable numbers (18% compared with 3-6% of persons in other facilities). Self-initiated contacts were least common in small group homes and small ICFs-MR (7% and 13% respectively, as compared with 20-29% in other facility types).

Prior Experience and Training

Between 40% and 60% of careproviders, depending on facility type, reported having prior experience with persons with mental retardation. The most common types of experiences indicated were working in another residential facility or a day program for persons with mental retardation,

volunteer work (0-19%), or relevant experience with elderly persons or persons having other handicaps. Some carepersons indicated that they had a relative with mental retardation. Careproviders in large foster homes (24%) and small group homes (13%) were the only respondents to mention state hospital or other noncommunity residential experiences.

The types of jobs which careproviders had held prior to their present job also differed by facility type. Careproviders in large foster care and small group homes were most likely to indicate direct residential experience (26% and 38% respectively, compared with 0-12% of careproviders in other facility types). ICF-MR careproviders were more likely than other respondents to indicate direct, nonresidential experience in the field (25% versus 3-6%).

Preservice training. Careproviders were asked whether they had taken any courses on mental retardation or on working with handicapped people as part of their general education in college or technical school. Between 26% and 47% indicated affirmatively. In many cases, specific training was required prior to starting their current job as a careprovider. Small foster care providers were least likely (X^2 (10) = 32.6, $p < .001$) to have been required to have preservice training, either for this job or for prior careprovider jobs (54% compared with 72-89% of careproviders in other facility types). The average number of training hours required, among those being required to have preservice training for the present position, ranged from 56-88 hours, with no statistically significant differences by facility type.

Inservice training. Careproviders in small group homes and in ICFs-MR of both sizes were most likely to report being required to receive a certain number of hours of training per year (X (5) = 21.8, $p < .0006$), with 79-83% of these careproviders reporting inservice training, as compared with 46 and 41% of foster careproviders and 42% of large group home providers. The total number of hours of training received in the last year, including careproviders receiving no training as well as those receiving nonrequired (elective) training, was approximately 17 hours for foster careproviders, and between 28 and 35 hours for others ($F=4.5$ [5,156], $p < .001$).

Adequacy of training. The majority of carepersons considered their training to have been adequate and appropriate. Overall, 6% indicated that they had received no formal training, and between

9 and 39% felt that they could use more training than they currently had received. Most respondents indicated that their training had generally been useful, 70% overall indicating that "most" of it had been useful, with 20% agreeing that only "some" portions had been useful. Only 4% felt it had not been useful.

Careprovider Role

Respondents were asked, in an open-ended question, to describe the most important part(s) of their role as a careprovider. Up to three responses were coded. The most frequently mentioned aspects were "growth, development, promote highest function, training," and "love, care, nurturing, support, friendship", both of which were mentioned by 18-50% of respondents. "Trying to help someone, make life better, happy residents" was mentioned by 11-26% of respondents, and "normalization" was indicated by 0-18%, depending upon facility type. Foster care providers were more likely than other providers to mention "food, shelter, clothing, and personal care", 18% of small and 33% of large foster care providers providing this response compared with 5-11% of other providers (X^2 (5) = 12.4, p = .03), and foster careproviders and large group home providers were most likely to indicate that they were "providing a family or home", 23 and 26% of foster care, 19% of large group homes, but only 0-8% of other providers indicating this response (X^2 (5) = 13.3, p = .02). Foster careproviders were least likely to report that "independence, or promoting dignity" was the most important part of their role, 0-4% of foster careproviders so indicating compared with 16-30% of other providers (X^2 (5) = 16.2, p < .01). Careproviders in larger ICFs-MR were most likely to mention "doing a good/professional job" (17% compared with 0-5% in other facility types [χ^2 (5) = 11.3, p < .05]), as well as to mention "good supervision, or quality of interaction of staff and clients", 17% so indicating compared with 0-11% in other facilities (X^2 (5) = 12.0, p < .05). Overall, few mentioned "protection and safety" (0-7%) as an important part of their role, and none indicated "efficiency or cost effectiveness".

Support and respect from other staff. When asked whether they felt that they were treated as an important and equal member of their residents' overall team of treatment professionals, most respondents said that they were. In addition, the majority of respondents felt that they received all the

support needed from case managers and staff from other programs in order to be as effective as they would like to be with residents. When indicated, the most commonly mentioned additional type of support or assistance desired was more administrative support, with between 33% and 100% of the respondents indicating that they needed additional supports or assistance mentioning this type of support. Better communication among service agencies was sometimes mentioned. More encouragement of initiative and decision-making and more training/education were also mentioned by a number of respondents.

Careprovider retention. Careproviders were asked to indicate the number of years that they estimated they would continue to be a careprovider. Overall, 10% said one year or less, and another 13% indicated 2-3 years. The average number of years indicated by careproviders differed by facility type. Foster careproviders expected to be careproviders longer than other providers, despite their more advanced age, averaging 9.7 and 5.3 years, respectively ($F\ [1,93] = 10.8\ p < .001$). Only 4% of foster careproviders expected to stay one year or less, as compared with 26% of other providers. Similarly, only 26% of foster care providers, but 69% of other providers, expected to stay no more than 5 years from the time of the survey. In addition, a substantial number of foster careproviders indicated that they expected to continue to be careproviders until they retired or were physically unfit (23% of small and 15% of large foster careproviders, as compared with 0-4% of other providers). Others offered responses such as "a few years" or "many years" (3-23% of all respondents), and approximately one-quarter of all respondents stated that they did not know how many years they would continue (20-34%).

Factors influencing decision to stay. A total of 139 respondents explained, in an open-ended question, the factors which had influenced their decision about the number of years they expected to be careproviders (up to two reasons were coded for each respondent). Foster careproviders were considerably more likely than other careproviders to mention age, health or retirement as a factor, 41% of small and 31% of larger foster careproviders citing these factors, compared with 0-6% of careproviders in other facilities ($X^2\ (5) = 26.2,\ p < .0001$). Career advancement to nondirect care was never mentioned by foster careproviders, but was indicated by 25% of respondents in larger ICFs-MR,

13% of respondents in larger group homes, and 4% and 9% of respondents in small group homes and ICFs-MR respectively (X^2 (5) = 14.2, $p < .02$). Direct care staff in larger group homes and larger ICFs-MR were more likely than careproviders in other facilities to indicate that they did not like the job conditions, hours, salary and/or administration, and that this was a factor in their decision to continue as a careprovider (20% and 31%, respectively, so indicating, as compared with 0-9% in other facility types (X^2 (5) = 17.3, $p < .005$). Between 12% and 47% mentioned that they liked the job or particular clients, and that this had influenced their decision; no respondents indicated that dislike of residents had been a factor in the continuation of their job.

Comparison by anticipated length of stay. Respondents who anticipated longer stays were compared with those who expected to remain direct careproviders for brief periods of time. Those anticipating longer stays were more likely to indicate that they felt that they were treated as important and equal members of the residents' overall team of treatment professionals (X^2 (5) = 13.1, $p < .05$), but they did not differ in the extent of support they reported from case managers and others. Respondents anticipating briefer stays were more likely to be college graduates or to have postgraduate degrees (X^2 (30) = 50.2, $p < .02$), were more likely to be still in school (although few respondents were in school) (X^2 (5) = 19.1, $p < .002$) and were less likely to be married (X^2 (25) = 52.3, $p < .001$). In addition, although only 17% overall indicated that they expected residents to stay less than three years, those staff so indicating were more likely to be among the staff anticipating leaving within that time period (X^2 (10) = 28.5, $p < .002$). Somewhat surprisingly, careprovider ratings of the extent of staff turnover in their facility and about problems in finding new staff were unrelated to their own expected length of stay.

Resident to staff ratios. Careproviders in group homes and ICFs-MR were asked to indicate the number of residents and the number of direct care staff in the facility on a typical weekday evening at 7:30 p.m. The total number of residents ranged from 2 to 6; staff from 1 to 4. The ratio of residents per staff was 2.4 and 3.4 in small and large group homes; 2.3 and 3.1 in small and large ICF-MR certified group homes. At a .05 level of significance (using the SNK procedure) small group homes or

small ICFs-MR had more staff to residents than large group homes. The ratio of residents to foster parents (not including their own children or other household members) was 1.5 residents per careperson in small foster homes and 3.5 per careperson in large foster homes.

Counting all group home carepersons on all shifts on all days (total number currently employed), residents of small group homes faced an average of 4.4 different staff per week, compared to 5.5 in large group homes. ICFs-MR had significantly larger numbers of total staff--7.0 and 8.5 in small and large facilities. The four types of staffed facilities (group homes and ICFs-MR) reported an average of 2.9 additional staff members who had worked at the facility throughout the preceding year (NS).

Staff salaries. Excluding foster care, beginning hourly wages ranged from $4.10 to $7.90, on the average, in the four types of staffed facilities; current hourly wages for the carepersons interviewed ranged from $5.40 to $9.60 in these facilities. Differences among facilities did not reach statistical significance.

Homes with two or more live-in houseparents. Few group homes or ICFs-MR had live-in staff (22 to 38%). Foster homes most typically had two foster parents (69% and 74% of small and large foster homes respectively, compared with only 6-15% of the other residential options. Approximately two-thirds of respondents in two houseparents homes reported that both were equally involved in the care of residents. Among foster homes, where one foster parent was designated the primary careprovider, the primary foster parent was almost invariably the wife (97%), but among group homes, there was a more even division between husband (33%), wife (44%) and "other" (22%) as the primary careprovider [X^2 (4) = 15.9, $p < .005$]. Two-thirds of group homes with 2 or more live-in careproviders indicated that the second person (usually spouse) was paid to live in. About half of the time, the other foster parent had a job in addition to being a foster parent (48% and 46% of small and large foster homes with 2 or more foster parents). This was true of one-third of group home live-in parents (differences did not reach statistical significance). Foster and group homes differed on the type of job of the nonprimary houseparent, with the nonprimary foster provider being more likely to have a day job which was related to special education (42% and 31% of small and large foster care, but none of the

group home or ICF-MR live-ins [X^2 (4) = 9.8, $p < .05$]). Night jobs and part time work were relatively uncommon. Persons designated as primary careproviders generally did not have other jobs, either within or outside of the home. In homes with 2 "houseparents" almost all primary careproviders reported that their spouse/other live-in liked being a careprovider as much or more than they did (83-100%). When asked who typically met with residents' social workers, day program staff and others, about two-thirds of primary careproviders (57-76% depending on the facility type), indicated that they were the most likely one to hold such meetings.

Other income sources for foster parents. Respondents who were foster parents (group homes and ICFs-MR excluded) were asked to indicate their annual household income, not counting reimbursements for foster care. The modal figure for large foster care was $10,000 per year or less (53% of large foster care respondents), whereas small foster care respondents were more likely to report the $10,001-20,000 range (40% of all small foster care parents), with only 26% reporting annual incomes of $10,000 or less ($X^2$ (5) = 12.4, $p < .05$).

Children of foster parents/live-in houseparents. Between 28% and 54% of facilities with one or more foster parents or live-in houseparents indicated that they had children of their own who lived with them in the foster group home. Approximately half of natural/adoptive children of foster parents (56% and 50% of small and large foster care, respectively) and all of the children of group home live-in staff were younger than the residents with handicaps. Respondents indicated a variety of ways in which their children were involved with residents. Between 40% and 93% depending on facility type, indicated that their children played or engaged in activities with residents as peers, 40-52% said they helped monitor residents, and a greater number (60-79%) reported that they helped teach residents, although less than one-third indicated that their children regularly cared for residents. Twenty-five percent of small foster and 80% of large foster care homes with children indicated that they paid their children if they helped with residents. A minority (7-20%) stated that their children were not very involved with residents.

Other assistance. Foster parents were asked a number of questions about other types of help or assistance which they used, such as a sitter or someone who stayed in the home when they were gone. Staff in larger foster care homes were more likely to indicate such help than staff in smaller foster care homes (86% versus 52% respectively, X^2 (1) = 8.4, $p < .005$). On the average, the 52% small foster care providers who had help received 17 hours per month of help compared with 67 hours per month for large foster care providers receiving such help (F [1, 48] = 6.8, $p < .02$). In addition, large foster care homes reported help .8 overnights per month, compared with .2 per month in small foster care (F (1.49) = 5.2, $p < .05$), as well as approximately 2 evenings per month. Rates of reimbursement for daytime help differed between the two size facilities, with large foster care averaging $3.20/hour, compared with $1.60/hour for small foster care facilities (F (1, 38) = 6.5, $p < .02$). Almost all (94%) foster careproviders indicated that these persons got along well with the residents; the rest indicated that they "get by OK". No respondents indicated any problems with additional help. Most respondents (64%) indicated that they had found this additional help "on their own," or through relatives. Very few foster careproviders found help through running a newspaper ad, through their foster care agency or through any other agency (less than 5%).

Direct care staff activities. Almost all direct care staff in group homes and ICFs-MR, both large and small, were involved in the preparation of meals (96-100%), and most (82-87%) did the laundry as well. Somewhat fewer were involved in maintenance functions (47-76%). Typically, direct care staff attended program planning meetings (80-94%), although they were less likely to set up program plans or meetings (53-67%), to write up program plans (40-68%) or to supervise other staff and schedule shifts (40-72%). Direct care staff in group homes and ICFs-MR rarely were responsible for hiring other staff (less than 15%).

Staffing problems. Group homes and ICFs-MR were asked a number of questions regarding staff turnover and more specific problems regarding staffing. About half (51%) of facilities indicated medium or high rates of turnover (about 20% indicated high rates), with no statistically significant differences attributable to facility type. Approximately 70% of respondents in these four facility types

indicated that they had problems finding new staff. Respondents mentioned a number of different types of problems with roughly equal frequency, including the difficulty of finding qualified staff (37-50% depending on facility type and size), reliable staff (33-46%), staff who are willing to work for the wages paid careproviders (33-46%), and staff for special shift hours (32-47%).

Professional staff support services. Table 3.7 reports the percent of facilities who had visits from professional support staff, and the average frequency of these visits. All respondents in ICFs-MR reported visits from nurses, many on a daily basis. Most nurses reported in ICFs-MR and group homes were on staff, i.e., on the home's payroll, but they were more likely to be paid by the agency/licenser in foster care homes. With the exception of nurses and teachers or staff from residents' schools or day programs who visited their students homes occasionally, foster homes were less likely to have professional home visits; ICFs-MR were most likely. The next chapter of this report will show that foster

Table 3.7
Periodic Home Visits by Other Professionals[1]

Staff	Foster		Group		ICF-MR		x^2/F
	1-4 (N=45)	5-6 (N=35)	1-4 (N=28)	5-6 (N=39)	1-4 (N=16)	5-6 (N=18)	
Nurse							
% of facilities	16.7%	30.8%	38.5%	19.2%	100.0%	100.0%	61.4**
N per year[2]	5.1	6.6	20.6	56.8	35.6	77.5	3.0*
Speech therapist							
%	0.0%	3.8%	26.9%	3.8%	35.7%	52.9%	38.8**
N per year	-	52.0	44.1	2.0	39.2	33.6	0.4
Physical therapist							
%	7.1%	3.8%	7.7%	7.7%	28.6%	35.3%	16.0**
N per year	37.3	1.0	55.0	131.0	18.3	32.5	1.0
Behavior specialist							
%	2.4%	3.8%	26.9%	11.5%	21.4%	35.3%	17.8**
N/yr	6.0	1.0	49.1	60.0	64.0	28.5	0.6
Teacher/day prog							
%	16.7%	34.6%	8.0%	42.3%	14.3%	47.1%	15.6**
N/yr	3.0	4.7	3.5	13.7	3.0	37.1	0.6
Psychologist							
%	14.3%	19.2%	16.0%	23.1%	71.4%	64.7%	31.5**
N yr	1.5	3.4	9.3	9.7	14.6	34.4	2.7*

[1] Does not include residents case managers.
[2] Average number of visits per year in homes that had visits.
* $p < .05$
** $p < .01$

home residents are likely to receive therapeutic services, but in their day programs rather than at home (see Tables 5.27 to 5.29).

Volunteers. With the exception of larger ICFs-MR, most facilities did not use volunteers. Small foster, group and ICF-MR homes were least likely to have volunteers, only 10-16% indicating affirmatively, compared with 26% of large foster, 40% of large group and 67% of large ICFs-MR (X^2 (15) = 31.6, $p < .01$).

CHAPTER 4

RESIDENT CHARACTERISTICS, RELATIONSHIPS, AND ACTIVITIES

This chapter describes the characteristics of residents of small residential settings, the services they receive, their relationships with family, friends and others, and their activities in the community. Unless otherwise indicated, the word "resident" will be used to refer to people with mental retardation who live in these homes, although foster parents and some staff are also residents of the sampled facilities.

Personal Characteristics

Table 4.1 presents information about age, sex, and diagnoses of residents in each facility group.

Age. Across all six facility samples, 11% of residents (excluding careproviders and their children) were children aged 0-14, 12% were 15-21 years old, and 77% were adults. The overall differences in the ages of residents in the different types and sizes of residential facilities were statistically significant (X^2 (20) = 49.5, $p < .01$). Foster home residents were more likely to be children and youth (32% between birth and 21 years as compared with 16% for the other facilities), and more likely to be older (8% were 63 years or older as compared with 3% in the other facilities). The proportion of children and youth age 21 or younger ranged from 7% in small ICFs-MR to 30% in small foster homes and 37% in large foster homes. It is apparent that family foster care is the most frequently used placement type for children who cannot live at home, but consistent with national trends toward fewer children and youth with mental retardation being placed out of natural or adoptive homes, foster homes in this study had a lower proportion of children and youth (0-21 years) than did specialized foster homes nationally in 1982 (37%).

Two residents in the study were less than 2 years old. Both lived in large 2 parent foster homes with other children. One infant, 5 1/2 months old, blind, with hydrocephaly, heart problems, and estimated to be severely mentally retarded came to the foster home straight from the hospital after

Table 4.1

Resident Age, Sex, Race, and Diagnosis

Characteristic	Foster		Group		ICF-MR		x^2
	1-4 (N=71)	5-6 (N=68)	1-4 (N=53)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
Age							
0-9	5.6%	17.6%	0.0%	1.3%	0.0%	0.0%	49.5**
10-14	7.0	5.9	5.7	5.2	0.0	5.7	
15-21	16.9	10.3	7.5	13.0	9.4	14.3	
22-62	64.8	55.9	86.8	76.6	81.3	80.0	
63+	5.6	10.3	0.0	3.9	9.4	0.0	
Sex							
Male	49.3%	52.9%	58.5%	53.2%	28.1%	54.3%	8.4
Female	50.7	47.1	41.5	46.8	71.9	45.7	
Race							
White	84.1%	85.9%	83.0%	93.1%	77.4%	91.4%	23.6
Black	11.6	4.7	13.2	6.9	22.6	5.7	
Asian	4.3	6.3	3.8	0.0	0.0	2.9	
American Indian	0.0	3.1	0.0	0.0	0.0	0.0	
Hispanic	3.2	12.1	1.9	7.4	15.6	6.1	9.1
Level of Retardation							
Borderline	1.4%	1.6%	0.0%	10.7%	0.0%	0.0%	40.8**
Mild	18.6	20.6	25.0	24.0	20.0	8.8	
Moderate	47.1	34.9	38.5	30.7	20.0	35.3	
Severe	27.1	30.2	21.2	24.0	46.7	29.4	
Profound	5.7	12.7	15.4	10.7	13.3	26.5	
Epilepsy							
Seizures controlled	7.0%	13.4%	11.3%	6.5%	15.6%	14.3%	24.5
Less than 1 per month	5.6	10.4	13.2	13.0	9.4	17.1	
Monthly	2.8	0.0	3.8	0.0	9.4	2.9	
Weekly or more often	4.2	7.5	1.9	2.6	3.1	0.0	
Total with epilepsy	19.6	31.3	30.2	22.1	37.5	34.3	

* $p < .05$
** $p < .01$

birth. Although her mother lived within 10 minutes travel time, she seldom visited her child at the foster home. The second infant was one year old with microcephaly, epilepsy, cerebral palsy, a gastrostomy, and estimated to be profoundly mentally retarded. He moved to the foster home from his parents' home when he was 7 months old. His parents visited about once a month.

Foster homes also had larger proportions of elderly residents than group homes did. The oldest resident in the study was a 79 year old man. He had severe mental retardation, high blood pressure, diabetes, and wore cataract glasses. He lived in a foster home with four other residents in

their 50s and foster parents in their late 60s. He was retired from a sheltered workshop and was recovering from recent prostate surgery. He had lived in the foster home for eight years.

Gender. There were no statistically significant differences among facility types with regard to residents' gender. Males and females were fairly evenly represented in the sample (51% versus 49%).

Race/ethnicity. Across all samples, the proportions of residents by race and ethnicity approximated the U.S. population. The relatively larger, but not statistically significant, proportion of Asians in foster homes may again be related to the fact that a large proportion of these homes, especially large foster homes, were in California.

Cognitive impairment. About 41% of the residents in the sampled facilities had severe or profound mental retardation. The proportion of residents who were borderline or mildly mentally retarded varied from approximately 20% in foster homes and small ICFs-MR to 35% in large group homes. The proportion of residents with mild mental retardation in large ICFs-MR was relatively small (9%). Conversely, the proportion of residents who were severely or profoundly mentally retarded was greater in large and small ICFs-MR (55-60%) than in other facilities (X^2 (20) = 40.8; $p < .01$) in which the proportion ranged from 32% to 37%.

Seizure disorders. The proportion of residents with seizure disorders ranged from 20% in small foster homes to 38% in small ICFs-MR, although the difference among facility types was not statistically significant. Approximately 40% of residents with epilepsy did not currently experience seizures. Frequent uncontrolled seizures (weekly or more often) were most common among residents of small and large foster homes (4.2% and 7.5%) and in small ICFs-MR (3.1%), but the differences among facilities was not statistically significant.

Functional limitations. Table 4.2 presents statistics on the mobility and functional limitations of residents in community-based living arrangements. Most residents could walk independently (70-80% depending on facility type) or with some help (10-20%). The proportion of foster home residents who were non-ambulatory was 8.5% in small homes and 14.7% in large homes. Small and large group homes were least likely to house nonambulatory residents (6% and 3%). Two residents were reported

to be "confined to bed." Both were children, 5 months and 14 years old, and both were tube fed, "suctioned," and had seizure disorders.

Table 4.2

Residents' Mobility and Functional Limitations

Characteristic	Foster		Group		ICF-MR		x^2
	1-4 (N=71)	5-6 (N=68)	1-4 (N=53)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
Mobility							
Walks well	75.7%	69.1%	83.0%	79.2%	65.6%	71.4%	47.1*
Walks with some help	10.0	14.7	9.4	15.6	25.0	14.3	
Walks with aids	5.7	1.5	1.9	2.6	3.1	5.7	
Propels wheelchair	0.0	2.9	5.7	1.3	0.0	0.0	
Pushed in wheelchair	7.1	2.9	0.0	1.3	6.3	8.6	
Bed most of day	0.0	7.4	0.0	0.0	0.0	0.0	
Confined to bed	1.4	1.5	0.0	0.0	0.0	0.0	
Total nonambulatory	8.5	14.7	5.7	2.6	6.3	8.6	
Vision							
No problem	69.0%	78.8%	77.4%	81.6%	81.3%	82.4%	12.3
Some problem	19.7	13.6	18.9	13.2	15.6	5.9	
Sees enough to walk around	5.6	1.5	1.9	3.9	3.1	5.9	
Blind	5.6	6.1	1.9	1.3	0.0	5.9	
Hearing							
No problem	75.7%	83.1%	88.7%	92.1%	90.6%	85.7%	23.9
Hears most things	17.1	12.3	7.5	1.3	9.4	8.6	
Hears loud noises	5.7	0.0	3.8	2.6	0.0	0.0	
Deaf	1.4	4.6	0.0	3.9	0.0	5.7	
Arm-Hand Use							
No limitations	84.3%	76.1%	90.6%	81.8%	78.1%	77.1%	11.4
Some limitations	11.4	14.9	9.4	16.9	18.8	17.1	
Great limitations (cannot hold spoon)	4.3	9.0	0.0	1.3	3.1	5.7	
Assistive Devices							
Eyeglasses	30.9%	27.7%	27.5%	27.4%	41.9%	26.5%	2.9
Hearing aids	11.8	7.7	5.9	2.7	9.7	2.9	5.9
Braces, slings, sp. shoes	4.4	6.2	2.0	0.0	12.9	8.8	10.8
Adaptive eating utensils	2.9	4.6	5.9	1.4	6.5	11.8	3.5
Protective helmet	1.5	3.1	3.9	2.7	12.9	2.9	8.6
Dentures	10.3	13.8	19.6	4.1	6.5	5.9	9.9

* $p < .05$
** $p < .01$

Sensory Impairments. Most residents were reported to have no visual problems (78%). About 4% of residents were reported to be legally blind, with blindness more commonly reported for residents of foster homes (6% as compared with 2.5%), but the difference was not statistically significant. Even

fewer residents were reported to have hearing problems. Careproviders reported that 86% of residents of small community facilities had no hearing problems, while only 3% were reported to be deaf.

Use of limbs. Residents' use of arms and hands was generally reported to be without limitation for 80% of residents. Limitations substantial enough to prevent the grasping of a spoon were reported for about 4% of residents.

Use of assistive devices. Use of basic assistive devices ranging from eye glasses to protective helmets did not vary significantly by type or size of residential setting. The most commonly used assistive device was eyeglasses (used by about 30% of residents).

Health problems. Respondents were asked to list "any health problems that require regular medical care." Table 4.3 shows that between 23% (small foster homes) and 40% (small ICFs-MR) of residents had special medical problems, though seldom requiring more than a monthly visit to a physician or nurse. The foster home residents who did require weekly medical visits were an infant with serious heart problems and a teenager who was self-abusive and was recovering from oral surgery. One group home resident went to a physician on her own at least once a week for what the careprovider described as hypochondriasis. She didn't have any health conditions that the doctor or the provider considered to be problems. Two ICF-MR residents, both from the same facility, were reported to need weekly nursing care consisting of steam treatments and postural drainage because of "chronic congestion."

Reasons for requiring medical care varied, but frequently included heart or respiratory problems. The only category for which a statistically significant difference existed was for skin problems (X^2 (5) = 13.1, $p < .05$) cited for three residents in small ICFs-MR. Only 17 of 77 residents with health problems requiring regular medical care were reported to have more than one special health problem. It must be stressed, however, that many residents had multiple health conditions that were not listed as requiring regular medical care. In fact carepersons in some facilities, especially in foster homes, performed procedures that in other facilities, especially ICFs-MR, were performed by nurses. For

example three foster parents managed their residents' gastrostomies; one group home staff person fed a resident with a nasal-gastric tube.

Table 4.3

Health Problems Requiring Regular Medical Care

Category	Foster 1-4 (N=71)	Foster 5-6 (N=68)	Group 1-4 (N=53)	Group 5-6 (N=77)	ICF-MR 1-4 (N=32)	ICF-MR 5-6 (N=35)	x^2
Special medical care req.							
No special care	77.1%	67.2%	67.9%	74.7%	60.0%	77.1%	27.0*
Less than monthly	18.3	11.6	26.1	21.1	20.0	11.4	
Monthly	4.6	17.4	6.0	2.8	20.0	5.7	
Weekly	0.0	3.9	0.0	1.4	0.0	5.7	
Total special care	22.9	32.9	32.1	25.3	40.0	22.8	
Reason for medical care							
Infectious or parasitic	0.0%	0.0%	1.9%	0.0%	0.0%	0.0%	5.4
Cancer	0.0	0.0	0.0	0.0	0.0	0.0	-
Endocrine/metabolic	2.8	1.5	7.5	1.3	0.0	0.0	8.4
Blood/blood forming organ	2.8	0.0	0.0	0.0	0.0	0.0	7.5
Psychosis	0.0	1.5	0.0	1.3	3.1	0.0	3.6
Nervous syst/sense organ	2.8	4.4	1.9	2.6	3.1	2.9	0.7
Circulatory system	4.2	5.9	7.5	2.6	6.3	0.0	4.0
Respiratory system	5.6	8.8	3.8	1.3	0.0	8.6	7.4
Digestive system	4.2	1.5	3.8	5.2	3.1	2.9	7.5
Genitourinary system	0.0	2.9	1.9	0.0	0.0	0.0	5.7
Skin/subcutaneous tissue	1.4	0.0	0.0	1.3	9.4	2.9	13.1*
Musculoskeletal	1.4	4.4	1.9	3.9	9.4	0.0	6.4
Other	0.0	1.5	0.0	0.0	0.0	0.0	11.9
Total 1 or more	22.9	32.8	32.1	25.3	40.0	22.9	
Limitations due to health							
Few limits	6.1%	11.5%	17.0%	11.9%	23.3%	11.4%	17.6
Many limits	6.1	4.9	0.0	0.0	3.3	0.0	
Total	12.2	16.4	17.0	11.9	26.6	11.4	
Prescribed medications							
For health problem	12.9%	21.0%	32.1%	28.9%	43.3%	31.4%	13.7*
For behavior	24.3	27.4	49.1	22.4	13.3	14.3	20.1**
For epilepsy	20.0	27.4	30.2	18.4	33.3	31.4	5.5
Other	7.1	4.8	3.8	6.6	6.7	11.4	2.4
Total one or more	48.6	67.7	79.2	60.5	66.7	68.6	13.7*

* $p < .05$
** $p < .01$

Only about half as many residents as had special health problems experienced limitations in daily activities because of the health problems. About 5-6% of residents of foster homes, none of the group home or larger ICF-MR residents, and 3.3% of small ICF-MR residents experienced "many limitations," although the observed differences among facilities were not statistically significant.

Many carepersons helped their residents with prescribed medications, which were used quite often in all facility types. The relative proportion of residents receiving medication for health problems varied from 13% in small foster homes to 43% in small ICFs-MR. Almost half (49%) of residents in small group homes, 22% of the residents in the larger group homes, 25% of foster home residents, and 14% of ICF-MR residents received psychotropic medication. About 20% to 30% of residents in all facility types were reported to receive medications for epilepsy.

Adaptive Behavior

Tables 4.4 and 4.5 report on the degree of assistance required by residents in several areas of adaptive behavior. In self help skill areas, foster home residents, especially those in large foster homes were least independent, group home residents were most independent, and ICF-MR certified group home residents were on average in-between. Between 16% and 31% of foster home and ICF-MR residents required physical assistance with at least some aspects of using the toilet; an additional 9% to 25% needed verbal guidance or reminders. At least half of group home residents, on the other hand, were independent in all self help skills.

In various community living skills, foster home residents were reported to be least independent and group home residents were most independent. Slightly more than half of residents of foster homes and ICFs-MR made their beds independently or with verbal reminders, compared to almost 80% of group home residents. Between 7% (small foster homes) and 26% (small group homes) of residents could prepare a meal independently or with verbal guidance; from 16% (small ICFs-MR) to 26% (small group homes) used the telephone independently. Approximately 10% of residents who had access to one could take a city bus independently, but less than 10% could purchase groceries independently, and only 2 residents could manage a checkbook.

Recall from Table 4.1 that many foster home residents were either very young or very old. Young children may often require added assistance because of their age rather than because of disability per se. Elderly persons may require added assistance because of conditions related to age rather than to their developmental disabilities. When only residents between the ages of 21 and 63

were included, foster home and ICF-MR residents were more similar in adaptive behavior, and were both somewhat lower in reported ability than group home residents, although differences were not usually statistically significant. However, in areas related to domestic participation (making beds, doing laundry, and preparing meals), the substantial, statistically significant differences between foster homes and the other facilities cannot be accounted for by differences in resident characteristics alone. This may suggest a need to improve orientation and training of foster care providers regarding the need to integrate activities that increase residents' self-reliance into daily life within the foster home.

Table 4.4

Adaptive Behavior: Assistance Needed With Self Care Skills

Skill Area	Foster		Group		ICF-MR		x^2/F
	1-4 (N=71)	5-6 (N=68)	1-4 (N=53)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
Toileting							
Mostly physical help	10.1%	25.0%	3.8%	2.6%	6.3%	8.6%	35.2*
Some physical help	5.8	5.9	9.4	6.5	12.5	14.3	
Verbal help/reminder	24.6	19.1	11.3	19.5	15.6	8.6	
Independent	59.4	50.0	75.5	71.4	65.6	68.6	
Eating							
Mostly physical help	7.2%	17.6%	0.0%	0.0%	3.1%	5.9%	33.2*
Some physical help	5.8	8.8	5.7	11.7	9.4	11.8	
Verbal help/reminder	26.1	22.1	15.1	18.2	21.9	26.5	
Independent	60.9	51.5	79.2	70.1	65.6	55.9	
Dressing							
Mostly physical help	11.6%	23.5%	3.8%	3.9%	3.1%	17.1%	33.6*
Some physical help	14.5	16.2	13.2	13.0	25.0	5.7	
Verbal help/reminder	29.0	19.1	17.0	20.8	12.5	25.7	
Independent	44.9	41.2	66.0	62.3	59.4	51.4	
Bath/Shower							
Mostly physical help	17.6%	32.3%	11.3%	13.0%	3.1%	25.7%	35.01*
Some physical help	16.2	14.7	18.9	10.4	34.4	8.6	
Verbal help/reminder	29.4	14.7	18.9	19.5	18.8	28.6	
Independent	36.8	38.2	50.9	57.1	43.8	37.1	

* $p < .01$

Table 4.5

Adaptive Behavior: Assistance Needed With Community Living Skills

Skill Area	Foster		Group		ICF-MR		x^2/F
	1-4 (N=71)	5-6 (N=68)	1-4 (N=53)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
Makes Bed							
Beyond ability	15.9%	30.9%	3.8%	5.3%	6.5%	14.3%	49.4**
Mostly physical help	4.3	7.4	7.5	6.7	6.5	11.4	
Some physical help	14.5	13.2	9.4	9.3	25.8	17.1	
Verbal help/reminder	18.8	10.3	18.9	28.0	0.0	22.9	
Independent	46.4	38.2	60.4	50.7	61.3	34.3	
Does Laundry							
Beyond ability	39.7%	48.5%	11.3%	9.2%	20.0%	20.0%	75.8**
Mostly physical help	23.5	13.6	9.4	10.5	10.0	14.3	
Some physical help	10.3	9.1	30.2	22.4	23.3	17.1	
Verbal help/reminder	20.6	21.2	13.2	31.6	23.3	31.4	
Independent	5.9	7.6	35.8	26.3	23.3	17.1	
Prepares meals							
Beyond ability	53.6%	50.0%	13.2%	22.4%	23.3%	25.7%	52.**
Mostly physical help	24.6	19.1	28.3	22.4	23.3	22.9	
Some physical help	14.5	13.2	32.1	28.9	43.3	28.6	
Verbal help/reminder	7.2	13.2	17.0	19.7	6.7	20.0	
Independent	0.0	4.4	9.4	6.6	3.3	2.9	
Uses Telephone							
Beyond ability	39.1%	47.1%	28.3%	28.6%	40.6%	38.2%	25.5
Mostly physical help	17.4	22.1	20.8	14.3	21.9	11.8	
Some physical help	8.7	8.8	11.3	19.5	21.9	11.8	
Verbal help/reminder	11.6	10.3	13.2	19.5	0.0	17.6	
Independent	23.2	11.8	26.4	18.2	15.6	20.6	
Uses City Bus							
Beyond ability	47.1%	58.5%	34.0%	37.0%	59.4%	50.0%	25.7
Mostly physical help	19.1	10.8	18.0	23.3	18.8	15.6	
Some physical help	5.9	4.6	18.0	16.4	12.5	3.1	
Verbal help/reminder	14.7	13.8	16.0	12.3	9.4	18.8	
Independent	13.2	12.3	14.0	11.0	0.0	12.5	
Buys Groceries							
Beyond ability	59.4%	57.4%	24.5%	31.6%	56.3%	38.2%	40.6*
Mostly physical help	18.8	17.6	32.1	27.6	15.6	26.5	
Some physical help	13.0	7.4	20.8	21.1	6.3	11.8	
Verbal help/reminder	4.4	8.8	18.9	11.8	9.4	20.6	
Independent	4.4	8.8	3.8	7.9	12.5	2.9	
Manages Checkbook							
Beyond ability	97.1%	88.2%	70.6%	72.0%	90.6%	84.8%	39.9*
Mostly physical help	1.4	7.4	17.6	18.7	3.1	9.1	
Some physical help	1.4	2.9	3.9	2.7	6.3	6.1	
Verbal help/reminder	0.0	0.0	7.8	4.0	0.0	0.0	
Independent	0.0	1.5	0.0	2.7	0.0	0.0	

* $p < .05$
** $p < .01$

Communication

Table 4.6 describes how residents communicated and how well residents were reported to understand other people. The proportion of residents who communicated primarily by talking ranged from 56% of residents of large ICFs-MR to 81% of small group home residents. Among residents who talked, in all types of facilities approximately 50% of talkers were considered easy to understand, 35% somewhat difficult to understand, and 15% difficult to understand. Although quite a few residents were reported to know some sign language, relatively few used this as their primary means of communication (3%). Group home and ICF-MR residents were more likely to sign than foster home residents, but the difference was not statistically significant. Likewise, more residents were reported to have some use of a symbol board or a symbol system (4% and 17%) than were reported to use these as their primary means of communication (2%).

Table 4.6

Residents' Method of Communication

Characteristics	Foster		Group		ICF-MR		χ^2/F
	1-4 (N=64)	5-6 (N=62)	1-4 (N=48)	5-6 (N=68)	1-4 (N=32)	5-6 (N=35)	
Primary Means of Communication							
Talks	73.4%	71.0%	81.2%	79.4%	71.9%	55.9%	33.5
Formal sign language	1.6	0.0	6.3	2.9	3.1	2.9	
Symbol system	0.0	3.2	4.2	1.5	0.0	5.9	
Sounds or gestures	15.6	8.1	8.3	8.8	21.9	20.6	
Cry or smile	9.4	16.1	0.0	7.4	3.1	14.7	
Other	0.0	1.6	0.0	0.0	0.0	0.0	
How Well Res Understands Others							
Understands most	55.7%	44.8%	67.9%	55.3%	65.6%	60.0%	28.9*
Understands if simplified	25.7	29.9	26.4	40.8	28.1	31.4	
Has difficulty with even simple sentences	11.4	11.9	5.7	2.6	3.1	2.9	
Turns head toward speaker but does not understand	7.1	13.4	0.0	1.3	3.1	5.7	

* $p < .05$
** $p < .01$

Careproviders were also asked how well residents understood other people who talked to them. The proportion of residents who were reported to understand most of what was said ranged from 45% of large foster home residents to 68% of small group home residents. Eleven percent of foster home, 3% of ICF-MR, and 4% of group home residents had difficulty understanding even simple sentences, and approximately 4% of ICF-MR residents and 10% of foster home residents did not appear to have any understanding of spoken language.

Problem Behaviors

This study used the *Inventory for Client and Agency Planning (ICAP)* (Bruininks, Hill, Weatherman, & Woodcock, 1985) to assess residents' problem behaviors in eight comprehensive categories. The number of types of problem behaviors exhibited by residents is shown in Table 4.7. The number of residents with at least one problem behavior ranged from a low of 46% in large group homes to a high of 90% in small group homes, where 25% of residents were reported to exhibit 5 or more types of problem behavior.

Table 4.7

Number of Categories of Problem Behavior Exhibited by Residents

Number of Problem Behaviors	Foster		Group		ICF-MR		x^2
	1-4 (N=71)	5-6 (N=68)	1-4 (N=53)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
1	13.2%	16.4%	18.8%	13.2%	34.5%	26.3%	
2	19.1	9.0	16.7	14.7	13.8	15.8	
3	4.4	11.9	14.6	7.4	20.7	15.8	
4	1.5	4.5	14.6	19.1	6.9	7.9	
5 or more	11.8	4.5	25.0	16.2	3.4	21.1	
Total	50.0	46.3	89.6	70.6	79.3	86.8	73.6*

* $p < .001$

Tables 4.8 and 4.9 provide information about the frequency and severity of problem behaviors. The ICAP groups problem behaviors into three areas: internalized, externalized and asocial. Internalized behaviors include hurting oneself, unusual habits (stereotyped behavior) and withdrawn or inattentive behavior. These behaviors, which were most common among group home residents and least common

Table 4.8
Prevalence and Frequency of Problem Behaviors

Problem/Frequency	Foster		Group		ICF-MR		x^2
	1-4 (N=71)	5-6 (N=68)	1-4 (N=53)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
Hurts Self							
Less than monthly	4.2%	3.1%	4.0%	1.4%	6.5%	5.7%	25.0
Monthly	4.2	3.1	8.0	9.5	6.5	2.9	
Weekly	0.0	4.6	6.0	9.5	3.2	14.3	
Daily	2.8	1.5	6.0	0.0	0.0	5.7	
Total	11.3	12.3	24.0	20.3	16.1	28.6	
Hurts Others							
Less than monthly	12.9%	3.0%	7.7%	14.5%	16.1%	20.0%	43.9**
Monthly	0.0	4.5	17.3	11.8	3.2	14.3	
Weekly	0.0	4.5	5.8	0.0	0.0	8.6	
Daily	1.4	1.5	0.0	0.0	0.0	2.9	
Total	14.3	13.4	30.8	26.3	19.4	45.7	
Damages Property							
Less than monthly	10.1%	3.0%	15.4%	11.8%	9.7%	8.6%	35.4*
Monthly	0.0	3.0	11.5	6.6	6.5	17.1	
Weekly	0.0	6.0	7.7	1.3	0.0	5.7	
Daily	1.4	0.0	0.0	1.3	0.0	2.9	
Total	11.6	11.9	34.6	21.1	16.1	34.3	
Disruptive Behavior							
Less than monthly	8.5%	3.0%	8.0%	9.1%	3.2%	5.7%	29.9
Monthly	7.0	3.0	12.0	11.7	9.7	14.3	
Weekly	0.0	7.5	20.0	9.1	9.7	17.1	
Daily	4.2	9.0	4.0	5.2	3.2	5.7	
Total	19.7	22.4	44.0	35.1	25.8	42.9	
Socially Unacceptable Behavior							
Less than monthly	4.3%	0.0%	5.9%	5.3%	0.0%	2.9%	31.1
Monthly	5.8	2.9	15.7	10.5	6.5	8.6	
Weekly	5.8	7.4	5.9	7.9	9.7	8.6	
Daily	2.9	1.5	11.8	5.3	3.2	17.1	
Total	18.8	11.8	39.2	28.9	19.4	37.1	
Uncooperative Behavior							
Less than monthly	5.6%	1.5%	5.9%	3.9%	9.4	5.7%	41.2**
Monthly	8.5	6.0	21.6	18.4	6.3	5.7	
Weekly	5.6	4.5	19.6	5.3	6.3	17.1	
Daily	1.4	6.0	7.8	3.9	0.0	8.6	
Total	21.1	17.9	54.9	31.6	21.9	37.1	
Unusual/Repetitive Habits							
Less than monthly	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	37.2*
Monthly	4.4	0.0	3.8	1.3	0.0	0.0	
Weekly	5.9	0.0	7.5	5.2	0.0	14.7	
Daily	11.8	9.0	24.5	28.6	16.1	20.6	
Total	23.5	9.0	35.8	35.1	16.1	35.3	
Withdrawn or Inattentive Behavior							
Less than monthly	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.2
Monthly	5.7	4.5	1.9	1.3	3.2	2.9	
Weekly	8.6	3.0	11.3	14.3	16.1	0.0	
Daily	4.3	7.5	9.4	9.1	6.5	2.9	
Total	18.6	14.9	22.6	24.7	25.8	5.7	

* $p < .05$
** $p < .01$

Table 4.9

Prevalence and Severity of Problem Behaviors

Problem/Severity	Foster		Group		ICF-MR		x^2
	1-4 (N=71)	5-6 (N=68)	1-4 (N=53)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
Hurts Self							
No/slight problem	9.9%	10.8%	18.0%	16.2%	16.1%	11.4%	27.9*
Moderate problem	1.4	1.5	2.0	4.1	.0	14.3	
Severe problem	0.0	0.0	4.0	0.0	.0	2.9	
Total	11.3	12.3	24.0	20.3	16.1	28.6	
Hurts Others							
No/slight problem	11.4%	7.5%	23.1%	21.1%	9.7%	34.3%	25.8*
Moderate problem	2.9	6.0	5.8	5.3	6.5	8.6	
Severe problem	0.0	0.0	1.9	0.0	3.2	2.9	
Total	14.3	13.4	30.8	26.3	19.4	45.7	
Damages Property							
No/slight problem	7.2%	10.4%	25.0%	15.8%	12.9%	22.9%	27.7*
Moderate problem	4.3	1.5	9.6	3.9	.0	5.7	
Severe problem	0.0	0.0	0.0	1.3	3.2	5.7	
Total	11.6	11.9	34.6	21.1	16.1	34.3	
Disruptive Behavior							
No/slight problem	11.3%	13.4%	34.0%	31.2%	16.1%	22.9%	26.8*
Moderate problem	7.0	6.0	6.0	3.9	6.5	17.1	
Severe problem	1.4	3.0	4.0	0.0	3.2	2.9	
Total	19.7	22.4	44.0	35.1	25.8	42.9	
Socially Unacceptable Behavior							
No/slight problem	7.2%	5.9%	29.4%	21.1%	9.7%	22.9%	26.7*
Moderate problem	10.1	5.9	7.8	5.3	6.5	8.6	
Severe problem	1.4	0.0	2.0	2.6	3.2	5.7	
Total	18.8	11.8	39.2	28.9	19.4	37.1	
Uncooperative Behavior							
No/slight problem	11.3%	11.9%	35.3%	21.1%	12.5%	22.9%	29.8*
Moderate problem	5.6	3.0	17.6	7.9	6.3	8.6	
Severe problem	4.2	3.0	2.0	2.6	3.1	5.7	
Total	21.1	17.9	54.9	31.6	21.9	37.1	
Unusual/Repetitive Habits							
No/slight problem	13.2%	4.5%	22.6%	26.0%	16.1%	35.3%	36.6**
Moderate problem	7.4	3.0	13.2	9.1	0.0	0.0	
Severe problem	2.9	1.5	0.0	0.0	0.0	0.0	
Total	23.5	9.0	35.8	35.1	16.1	35.3	
Withdrawn or Inattentive Behavior							
No/slight problem	7.1%	9.0%	13.2%	14.3%	19.4%	2.9%	13.6
Moderate problem	7.1	4.5	7.5	9.1	6.5	2.9	
Severe problem	4.3	1.5	1.9	1.3	0.0	0.0	
Total	18.6	14.9	22.6	24.7	25.8	5.7	

* $p < .05$
** $p < .01$

in foster homes, tended to occur on a daily or weekly basis, but usually presented no problem or only a slight problem for staff (Table 4.9).

Externalized behaviors included hurting other people or disrupting their activities, or damaging property. Although the prevalence of these behaviors was similar to the prevalence of other maladaptive behaviors, ranging from 12% of foster home residents who damaged property to 46% of large ICF-MR residents who hurt other people, the frequency of behaviors tended to be very low--typically not more than once a month, and the severity of these problems for approximately three-fourths of residents who exhibited them was reported to be "none" or "slight." Behaviors that hurt other people or damaged property were reported to be severe problems for one or two residents (1.9% to 5.7%) in each of the group home and ICF-MR groups.

Asocial behavior categories included socially unacceptable behavior (for example, improper or annoying behaviors in public) and uncooperative behavior (refusing to follow rules). The incidence of these behaviors ranged from 12% to 55% of residents for behaviors that occurred anywhere from daily (17% of large ICF-MR residents) to less than monthly.

In order to gain an overall idea of the extent of maladaptive behavior in these small facilities, an ICAP General Maladaptive Behavior Index score was computed. Results are presented in Table 4.10. This ICAP score has an average age adjusted score of 0 for non-handicapped persons, and a standard deviation of 10 for people with mental retardation. Negative scores indicate more serious maladaptive behavior, based on the frequency and severity of the eight categories of behavior. The ICAP scores indicate average levels of maladaptive behavior overall, with small group home residents reported to exhibit more serious maladaptive behavior than either foster home or ICF-MR residents, and large ICF-MR residents more serious behavior than foster home residents ($p < .05$ using SNK procedure; $F(5,309) = 4.7$, $p < .001$). Perhaps most interesting is that despite the fact that each type of facility had one or more residents with very serious problem behaviors, the average score for all residents was quite modest, within the range considered normal.

Table 4.10

Residents' Overall Problem Behavior Scores
on the *Inventory for Client and Agency Planning*

	Foster		Group		ICF-MR		
	1-4	5-6	1-4	5-6	1-4	5-6	F
Minimum	-34	-27	-34	-27	-21	-38	
Maximum	4	4	4	4	4	4	
Mean	-1.3	-1.0	-6.6	3.1	-1.6	-6.7	4.7*
SD	7.5	8.0	9.3	7.7	6.5	10.9	

* $p < .001$

Table 4.11 presents additional information about problem behaviors. This table is based on the total number of problem behavior categories reported for all residents (up to eight problems could have been reported for each resident). In all types of facilities, carepersons reported that more than half of all problem behaviors had decreased since the resident first came to the home, 20% to 30% of behaviors had not changed, and 9% to 19% had increased in frequency. An increase occurred more often in large facilities (i.e., 5 or 6 residents).

Carepersons were fairly consistent in the manner in which they responded to problem behaviors, with verbal responses (ask resident to stop) most common, followed by differential reinforcement of other behaviors. ICF-MR staff members were more likely to report that they structured the environment to avoid or prevent problems (no information was gathered on what this structure consisted of), but they were also more likely to redirect or restrain clients. The results of these methods of controlling behavior were also reported. Approximately 80% of efforts to manage behavior were reported to be resulting in decreases in the problem. Likewise, 60-80% of the time, carepersons felt that current efforts to manage behavior were adequate. For 6-20% of behaviors staff felt that added staff training would help; some large foster homes and large ICFs-MR felt that a better staff ratio would help, and 4-18% wanted on-site consultation. Group home and ICF-MR staff members were more likely than foster homes to have stated that a resident should be demitted, apparently having given up on managing a particular client's problem behavior.

Table 4.11

Careperson Comments About Maladaptive Behavior

	Foster		Group		ICF-MR	
	1-4 (N=97)	5-6 (N=76)	1-4 (N=149)	5-6 (N=170)	1-4 (N=51)	5-6 (N=94)
Change Since Admission						
Less often	55.3%	58.6%	56.1%	56.4%	56.5%	58.5%
Same	35.1	22.9	33.1	31.4	34.8	24.4
More often	9.6	18.6	10.8	12.2	8.7	17.1
Staff Response to Problem Behaviors						
Do nothing	9.6%	7.8%	6.1%	4.7%	7.7%	4.3%
Ask to stop, reason	35.1	39.0	37.8	38.0	34.6	23.4
Ignore, reward other behaviors	16.0	14.3	19.6	19.3	23.1	18.1
Ask to make amends	8.5	10.4	11.5	10.5	11.5	10.6
Restructure surroundings	1.1	.0	3.4	2.3	5.8	8.5
Time-out	14.9	19.5	10.1	10.5	7.7	16.0
Take away privileges	6.4	3.9	1.4	11.7	3.8	6.4
Redirect or restrain	2.1	2.6	6.8	2.3	5.8	9.6
Get help	.0	.0	.7	.0	.0	1.1
Other	6.4	2.6	2.7	.6	.0	2.1
Result of Current Efforts						
Significant decrease	37.9%	39.5%	29.7%	38.5%	23.1%	33.0%
Some decrease	45.3	38.2	38.5	40.2	46.2	35.1
No change	14.7	17.1	29.7	18.9	30.8	25.5
Gotten worse	2.1	5.3	2.0	2.4	.0	6.4
Additional Steps						
None, OK as is	72.2%	78.9%	63.8%	68.4%	72.5%	72.3%
Staff need special training	14.4	7.9	7.4	20.0	5.9	7.4
Need more staff	2.1	6.6	.7	.6	.0	6.4
Need special on-site consultant	7.2	7.9	10.7	8.8	17.6	4.3
Resident should be removed	1.0	.0	9.4	3.5	3.9	6.4
Other	7.2	.0	4.7	6.5	3.9	4.3

Note. N indicates number of resident behaviors. Up to eight types of behavior could be counted for each resident.

Placement History

The age at which residents of these facilities originally moved away from their natural families is summarized in Table 4.12. Review of this table indicates a significant relationship between age and type of placement. Nearly 50% of residents in foster homes and small ICFs-MR were placed before the age of 10 years; proportionately fewer persons this young entered group homes. An interesting finding is the very high rates of placements among persons 40 years or over. The highest placement rate was found in group homes with approximately 53% of the persons placed after their fortieth birthday. The differences in age of placement by type of program were statistically significant (X^2 (25) = 47.4, p <

.01). Two factors seem to account for these age differences. First, foster homes and small ICF-MR group homes seem to be used proportionately more for younger children, while group homes seem to be used to a much greater extent for middle aged individuals. Second, for these small facilities there seem to be two patterns of placement represented in the data, one for relatively high proportions of persons to be placed before the age of 10 and a second large group placed after the age of 40 years. The older placements may be related to the fact that persons who stayed at home until this age, themselves and/or their families, wished to maintain a lifestyle in a typical, community based housing arrangement.

Table 4.12

Age of Residents When Originally Moved Away From Parents

Age left home	Foster		Group		ICF-MR		x^2
	1-4 (N=70)	5-6 (N=62)	1-4 (N=51)	5-6 (N=73)	1-4 (N=30)	5-6 (N=35)	
0-4	28.6%	30.6%	5.9%	6.8%	33.3%	11.4%	47.4*
5-9	15.7	19.4	13.7	9.6	13.3	14.3	
10-14	2.9	6.5	9.8	8.2	6.7	2.9	
15-21	7.1	1.6	11.8	11.0	10.0	14.3	
22-39	2.9	6.5	5.9	12.3	3.3	17.1	
40+	42.9	35.5	52.9	52.1	33.3	40.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

The data on the number of years the residents had lived in their present facility are reported in Table 4.13. There is some variation in the duration of placements by facility type and a significance test indicates that there is a strong relationship between duration of placements and type of facility (X^2 (15) = 81.3, $p < .01$). Some foster home placements within the sample (5%) had been maintained for more than 20 years. Most of group homes and ICFs-MR, however, had placements that were five years or less in duration, as recent depopulation of public residential facilities has made rather heavy use of group homes and small ICFs-MR as alternative placements. Nearly 30% of residents in foster placements had lived in their present location for a period of at least eleven years. The average

duration of placements in foster homes was 9 years, compared to an average of about 3 years in group home and ICF-MR group home residences ($F = 12.69$, $df = 5$, $p < .01$).

Table 4.13

Number of Years Resident Has Lived in the Present Facility

Number of Years	Foster		Group		ICF-MR		x^2
	1-4 (N=69)	5-6 (N=58)	1-4 (N=50)	5-6 (N=68)	1-4 (N=31)	5-6 (N=33)	
0-5	26.1%	31.0%	72.0%	60.3%	48.4%	84.8%	81.3*
6-10	36.2	39.7	24.0	35.3	51.6	6.1	
11-20	31.9	25.9	4.0	2.9	0.0	9.1	
20+	5.8	3.4	0.0	1.5	0.0	0.0	
Average	9.35	8.74	4.36	5.06	5.42	4.21	12.0*
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Data on previous residential placements are summarized in Table 4.14. The largest single previous placement in all categories was state institutions. Approximately 40% of foster home residents, 50% of group home residents and 65% of current ICF-MR residents resided in state institutional settings immediately prior to their current placement. The second largest previous placement was from the homes of parents or relatives, although approximately 25% of foster home residents had lived in a different foster home. A relatively large number of previous placements for group homes and larger foster homes came from natural families or relatives. Although there are some differences within placement categories by size of facility, these differences did not yield statistically significant differences by size alone.

Table 4.15 summarizes reasons given for residents having moved from their previous residential placement. Reasons varied quite widely. Some related to the characteristics of the individual; others were more policy-related, including the closing of facilities and the consequences of statewide planning initiatives related to state plans for deinstitutionalization, and the decision to place individuals in less structured and more independent living settings. There is considerable indication in these data that most movement relates to individual or organizational preference for small foster homes and small group

Table 4.14

Types of Placement Immediately Before Moving to the Present Facility

Previous Placement	Foster		Group		ICF-MR		x^2
	1-4 (N=61)	5-6 (N=57)	1-4 (N=50)	5-6 (N=66)	1-4 (N=31)	5-6 (N=33)	
With parents or relatives	14.8%	26.3%	30.0%	25.8%	12.9%	15.2%	67.2*
Foster home	23.0	24.6	4.0	6.1	3.2	15.2	
Indep. in own home or rental unit	0.0	0.0	0.0	1.5	0.0	0.0	
Room & board without personal care	1.6	0.0	0.0	3.0	0.0	0.0	
Semi-independent unit with supervisory staff in building	0.0	0.0	2.0	0.0	3.2	0.0	
Group res. with staff providing care, supervision and training	9.8	10.5	14.0	12.1	9.7	27.3	
Personal care facility with staff providing care, but no training or nursing services	1.6	1.8	0.0	0.0	0.0	0.0	
Nursing home	1.6	1.8	4.0	3.0	0.0	0.0	
State institution	41.0	35.1	46.0	48.5	67.7	42.4	
Other	6.6	0.0	0.0	0.0	3.2	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .05$

homes as means of achieving personal or public goals of increasing the integration and/or decreasing the institutionalization of persons with mental retardation. In terms of individual characteristics, the most common reason for a change in placement was presence of a behavior problem, although this factor was mentioned in a relatively small (and not statistically significant) percentage of the cases. Family reasons obviously were associated with some decisions for placement.

Table 4.16 summarizes reasons given by careproviders for sample members having moved into the present residential placement rather than into some other facility. The reasons for placement in the current facility are quite varied, but most of the reasons seem to involve a decision to find a more appropriate program and related services, or environments more home-like than offered by other facilities.

Additional information about placement history is found in Table 4.17. It summarizes the average number of previous placements for all residents, not including the present placement or the individuals'

Table 4.15
Reasons for Moving Out of Last Residence

Reasons	Foster		Group		ICF-MR		x^2
	1-4 (N=48)	5-6 (N=44)	1-4 (N=44)	5-6 (N=60)	1-4 (N=24)	5-6 (N=30)	
Behavior problems	6.3%	4.5%	4.5%	11.7%	4.2%	3.3%	140.9
Medical or health problems	2.1	4.5	-	-	-	-	
Too old/strong/big for facility/home to manage care	-	2.3	2.3	-	-	3.3	
Court-ordered, reason unspecified ("taken by state")	-	4.5	-	1.7	-	-	
Court commitment; resident had trouble with the law	-	2.3	-	1.7	-	-	
Problems with resident	2.1	-	-	-	-	-	
Facility offers better program; necessary program/service available; appropriate peer group	6.3	2.3	9.1	6.7	16.7	-	
Programming or service needs not adequate/available	4.2	6.8	9.1	8.3	4.2	6.7	
Resident had completed prog. available, reached age, skill/time limit on prog.	2.1	-	-	5.0	4.2	-	
Ready for less structured program; higher functioning than others here; ready for move into community	8.3	4.5	20.5	20.0	33.3	46.7	
Parents couldn't handle him any longer	8.3	6.8	9.1	5.0	4.2	-	
Sought more home-like environment	12.5	9.1	-	1.7	4.2	3.3	
Family reason: no longer able to care for resident/death or illness of family members or family care person; needs of other family members	8.3	6.8	13.6	8.3	-	6.7	
Neglect or abuse of resident at previous residence	2.1	6.8	-	3.3	-	3.3	
Previous facility closed	16.7	22.7	15.9	5.0	8.3	3.3	
Previous facility changed type of resident, was overcrowded; other administrative reasons to do with previous facility	-	2.3	-	-	4.2	-	
Previous residence not a placement--discharge and readmission for administrative reasons only, i.e., hospitalization, home visit	2.1	2.3	-	-	-	-	
Part of state plan to deinst., etc.	12.5	2.3	2.3	13.3	12.5	6.7	
Parents chose	4.2	-	-	-	-	3.3	
Careprovider chose	-	-	-	-	-	3.3	
No special reason	-	-	2.3	1.7	-	-	
Resident wanted to move	-	2.3	-	-	-	3.3	
Recommended by doctor or other professional	-	2.3	4.5	1.7	-	-	
Others (family) responsible for resident wanted the move	2.1	2.3	4.5	1.7	-	3.3	
Other	-	2.3	2.3	3.3	4.2	3.3	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

Table 4.16

Reasons for Moving Into the Present Facility Rather Than Into Another Facility

Reasons	Foster		Group		ICF-MR		x^2
	1-4 (N=56)	5-6 (N=47)	1-4 (N=41)	5-6 (N=59)	1-4 (N=16)	5-6 (N=28)	
Behavior problems	1.8%	0.0%	2.4%	0.0%	0.0%	0.0%	174.8*
Medical or health problems	1.8	0.0	0.0	0.0	0.0	0.0	
Facility offers better program; necessary program/service available; appropriate peer group	26.8	27.7	41.5	47.5	37.5	35.7	
Ready for less structured program; ready for move into community	0.0	0.0	9.8	1.7	0.0	10.7	
Sought more home-like environment	12.5	6.4	0.0	0.0	0.0	0.0	
Part of state plan to deinst., etc.	0.0	0.0	0.0	0.0	18.8	3.6	
No other placement available	3.6	8.5	2.4	0.0	6.3	7.1	
Parents chose	3.6	12.8	4.9	13.6	6.3	10.7	
Resident chose	0.0	8.5	0.0	0.0	0.0	0.0	
Caseworker chose	16.1	8.5	2.4	3.4	6.3	0.0	
Careprovider chose	14.3	4.3	2.4	3.4	0.0	0.0	
No special reason	14.3	12.8	26.8	13.6	12.5	14.3	
Resident wanted to move	1.8	4.3	0.0	0.0	0.0	0.0	
To be close to family/guardian	3.6	0.0	7.3	15.3	0.0	3.6	
Others (family) responsible for resident wanted the move	0.0	0.0	0.0	0.0	0.0	3.6	
Other	0.0	6.4	0.0	1.7	12.5	10.7	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

natural homes. The single most common was state residential institutions. This was particularly frequent of individuals living in small ICF-MR group homes, who had on average had more than one stay in a state institution (1.3). Within foster homes, the most common previous placements were other foster home settings and state institutions, with an average of .62 and .57 previous placements respectively. Expressed in another way, it is estimated that in a typical group of 100 foster home residents with mental retardation, group members would among themselves have had at one time or another a total of 62 placements in other foster care homes and 57 placements in state institutions. Nursing homes did not appear to provide many of the previous placements of persons residing in foster homes and group homes. Across all group types of facilities, the average resident in different facility types had been in 1.3 to 2.7 other facilities, that is, was living in his/her third out-of-home placement at the time of this survey.

Table 4.17

Average Number of Times Residents Had Been Placed
in Other Facilities (not counting natural home or present placement)

Previous placements	Foster		Group		ICF-MR	
	1-4 (N=70) Mean	5-6 (N=68) Mean	1-4 (N=53) Mean	5-6 (N=78) Mean	1-4 (N=32) Mean	5-6 (N=35) Mean
Foster home(s)	.62	.62	.12	.18	.10	.13**
Group home(s)	.24	.24	.37	.30	.27	.32
Nursing home(s)	.16	.00	.02	.02	.00	.00*
Institution(s)	.69	.46	.67	.60	1.58	1.08**
Other	.11	.02	.14	.06	.07	.12
Total other placements	2.0	1.8	1.3	1.5	2.7	2.0 *

Note. Total may not equal sum of columns because of varying missing values for individual items.
* $p < .05$
** $p < .01$

Present and Future Placement

The survey also requested the careprovider's assessment of the extent to which the resident was satisfied with his or her present home in comparison with previous placements. Responses are shown in Table 4.18. Obviously this information is subjective, and prone to bias. It was most commonly reported that the resident "likes the current placement more" or "likes it well." Approximately 80% or

Table 4.18

Degree of Residents' Liking of the Present Facility Compared to Other Placements

Degree of Liking	Foster		Group		ICF-MR		x^2
	1-4 (N=61)	5-6 (N=48)	1-4 (N=47)	5-6 (N=67)	1-4 (N=30)	5-6 (N=31)	
Likes it more or likes it well	85.2%	87.5%	83.0%	86.6%	73.3%	80.6%	34.2
Likes it less than some other	3.3	0.0	0.0	3.0	6.7	3.2	
Likes it about the same	6.6	2.1	10.6	3.0	0.0	6.5	
Prefers parents	0.0	2.1	4.3	6.0	13.3	6.5	
Prefers own apartment or more indep.	0.0	0.0	2.1	0.0	0.0	3.2	
Other	4.9	8.3	0.0	1.5	6.7	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

more of the individuals in all types of placement were reported to like their current placement at least as well or better than their previous placements.

Respondents were also asked to indicate whether there were future plans for the resident to move to another placement. As shown in Table 4.19, the most frequent response to this question was "no." Still, plans for future movement were reported for 29% of all sample members. Although the differences were not particularly large, there was a greater trend for projecting alternative placements

Table 4.19

Plans for the Resident to Move and Eventual Placement of Greatest Independence

	Foster		Group		ICF-MR		x^2
	1-4 (N=67)	5-6 (N=58)	1-4 (N=49)	5-6 (N=71)	1-4 (N=28)	5-6 (N=34)	
Decision							
No	67.2%	79.3%	61.2%	56.3%	75.0%	50.0%	14.6
Yes	23.9	17.2	30.6	38.0	21.4	41.2	
Don't know	9.0	3.4	8.2	5.6	3.6	8.8	
Total	100.0	100.0	100.0	100.0	100.0	100.0	
Eventual Placement of Greatest Independence							
Foster home	12.3%	20.0%	0.0%	10.4%	3.7%	3.1%	111.9*
Independent in own home or rental unit	3.1	2.0	4.3	9.0	3.7	0.0	
Indep. with regular home-base services or monitoring	3.1	6.0	12.8	9.0	0.0	9.4	
Room and board without personal care	1.5	0.0	0.0	0.0	0.0	6.3	
Semi-indep. unit with supervisory staff in building	3.1	6.0	17.0	10.4	7.4	15.6	
Group res. with staff providing care, supervision and training (group home)	18.5	16.0	21.3	29.9	55.6	31.3	
Personal care facility with staff providing care, but no training or nursing services	0.0	2.0	0.0	3.0	0.0	0.0	
Intermediate care facility	0.0	4.0	0.0	0.0	0.0	0.0	
Skilled nursing facility	0.0	2.0	0.0	0.0	0.0	0.0	
State institution	0.0	2.0	0.0	0.0	0.0	0.0	
The present home	29.2	8.0	25.5	16.4	14.8	21.9	
Unspecified place w/continuous supervision	29.2	32.0	19.1	11.9	14.8	12.5	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

among group home and ICF-MR residents than among foster home residents. When asked about the possible time-table for moving residents, respondents gave a variety of answers. The most common response by foster parents was age-related, for example, when the resident reached the age of 18-21

years. Other responses were related to the availability of alternative placements. A more common response for future movement of group home residents was based upon anticipated improvement in the level of a person's independence in functional living skills. Behavior problems were listed as very infrequent barriers to possible movement.

Respondents were also asked to estimate the most independent living arrangement they felt each resident would attain in future years. The most common was "this home" or an environment with a similar degree of supervision. However, a number of estimates were made that residents were capable of living in less-supervised environments sometime in the future. The patterns of responses indicate the relatively even split in the projected future placements of current residents. Approximately equal numbers of individuals felt that some form of more independent setting would be possible, or that the current placement or some similar level of supervision was appropriate.

Relationships in the Home

Respondents were asked a series of questions about the role of their residential settings and about how they believed residents perceived themselves within that setting. Table 4.20 shows how carepersons rank ordered a group of five descriptors. Foster parents viewed what their residences offered first as "a family" and nearly equally as "a home." Group home and ICF-MR respondents ranked "home" as most important, but "training program" above "family." Small and large foster homes and small ICFs-MR ranked "family" significantly higher than group homes did (using SNK, $p < .05$). Large and small foster homes ranked training as a significantly less important descriptor. Being a "support for the residents' parents" and "being a transition program" to a less restrictive setting were ranked as least important descriptors of their purpose by all groups of residence.

Asked how they viewed their relationship with residents, there was a clear difference between foster parents, 80% of whom perceived residents as "family members," and group home staff who

Table 4.20

Relationships in the Home

Relationship	Foster		Group		ICF-MR		F/X^2
	1-4 (N=68)	5-6 (N=65)	1-4 (N=53)	5-6 (N=75)	1-4 (N=32)	5-6 (N=35)	
Purpose home serves for resident (1=most important)							
It's a home	1.60	1.88	1.67	1.83	1.72	2.03	1.5
It's a training program	3.16	3.15	2.59	2.57	2.86	2.57	5.3**
Support program for the resident's parents	4.53	4.33	4.47	4.47	4.67	4.80	2.1
It's a family	1.72	1.68	2.62	2.83	2.02	2.94	18.2**
It's a transition to a less restrictive setting	3.99	3.95	3.64	3.30	3.73	2.66	9.5**
How careperson perceives resident							
A boarder	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	165.3*
Friend	11.3	14.7	51.9	62.7	46.9	48.6	
Acquaintance	0.0	0.0	7.7	2.7	0.0	0.0	
Family member	81.7	80.9	17.3	24.0	25.0	11.4	
Trainee	2.8	1.5	15.4	5.3	25.0	34.3	
Other	2.8	2.9	7.7	5.3	3.1	5.7	
Total	100.0	100.0	100.0	100.0	100.0	100.0	
How residents perceive themselves[1]							
An outsider	0.0%	0.0%	1.9%	1.3%	3.1%	0.0%	131.1*
A boarder	1.4	0.0	5.8	2.6	0.0	0.0	
Friend	19.7	20.6	36.5	31.6	28.1	57.1	
Acquaintance	0.0	1.5	5.8	9.2	0.0	8.6	
Roommate	2.8	1.5	17.3	26.3	28.1	17.1	
Family member	71.8	72.1	17.3	19.7	40.6	8.6	
Trainee	1.4	2.9	3.8	2.6	0.0	2.9	
Other	2.8	1.5	11.5	6.6	0.0	5.7	
Total	100.0	100.0	100.0	100.0	100.0	100.0	
Who resident feels closest to[1]							
No one special	2.8%	0.0%	3.8%	4.0%	6.5%	0.0%	179.7**
He or my spouse	84.5	80.9	25.0	20.0	29.0	17.1	
One of my children	4.2	4.4	0.0	1.3	0.0	0.0	
Another member of my family	2.8	0.0	3.8	0.0	0.0	0.0	
Another resident here	2.8	1.5	9.6	16.0	19.4	11.4	
One of his/her relatives	0.0	7.4	28.8	25.3	16.1	28.6	
Another staff person	0.0	1.5	9.6	9.3	25.8	20.0	
Another person from outside home	1.4	1.5	1.9	9.3	3.2	8.6	
Other	1.4	0.0	5.8	5.3	0.0	2.9	
Don't know	0.0	2.9	11.5	9.3	0.0	11.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

[1] As reported by careperson.

* $p < .01$

** $p < .001$

perceived residents as "friends" or "trainees." This pattern was fairly well reflected in a related question in which carepersons were asked how they believed residents perceived their own relationship with careproviders, although carepersons did not often report "trainee" as the residents' perceived role.

Foster home residents were reported to feel "closest to" the foster parent (80%), to a foster parent's child or relative (8%), to another resident (2%), or to a member of their own natural family (4%). Group home and ICF-MR residents were reported to feel closest to the careperson (about 25%), to one of his/her (the resident's) own relatives (about 15%) or to another resident (about 25%). For about 10% of group home residents, the careperson did not feel that they knew who the resident felt closest to.

Expectations and Preferences of Residents

Table 4.21 lists the proportion of residents who are regularly expected to help with a variety of household tasks. Making the bed, setting the table, and cleaning the bedroom were expected of 80-90% of group home residents and 60-80% residents in ICFs-MR and foster homes. In a special analysis that included only ambulatory adults who could talk (recall that foster homes had relatively larger proportions of children and physically handicapped adults) the statistically significant differences ($p < .05$) in household tasks was maintained for laundry, taking out the trash, vacuuming, cooking or setting the table, buying groceries, and cleaning rooms other than the bedroom. Group home residents were most likely, and foster home residents least likely to be expected to perform these tasks. Within each of the three facility types, residents in small homes were slightly more involved than residents of large homes.

In an attempt to determine how well carepersons knew residents' personal preferences, they were asked if each resident had a favorite food, a disliked food, and a favorite possession. Of special interest were the proportions of careproviders who did not know. Collapsing across size, group home staff were less likely than ICF-MR staff and foster parents to know if residents had specific dislikes among foods (16%, 12%, 6%; $p < .05$) or had favorite possessions (7% in group homes, 3% foster, and 1.5% in ICFs-MR; $p < .05$). Combining types of facilities, there were no significant differences between large (5 or 6 residents) versus small (4 or fewer residents).

Table 4.21

Household Activities and Resident Preferences

	Foster		Group		ICF-MR		
	1-4 (N=68)	5-6 (N=63)	1-4 (N=52)	5-6 (N=76)	1-4 (N=30)	5-6 (N=35)	
Household tasks regularly expected of resident							
Laundry	30.9%	30.2%	82.7%	76.3%	70.0%	74.3%	69.7***
Taking out the trash	50.0	52.4	78.8	77.6	63.3	71.4	21.6***
Vacuuming, cleaning	42.6	41.3	88.5	81.6	66.7	74.3	53.3***
Mowing the grass	11.8	14.3	19.2	18.4	20.0	14.3	2.2
Making the bed	75.0	61.9	96.2	93.4	86.7	68.6	35.3***
Help cook or set table	39.7	46.0	90.4	78.9	73.3	74.3	52.6***
Do dishes	51.5	46.0	76.9	77.6	66.7	65.7	23.3***
Buy groceries	11.8	15.9	69.2	42.1	36.7	28.6	56.4***
Cleaning own room	73.5	61.9	94.2	81.6	76.7	71.4	18.5**
Cleaning other parts of house	36.8	36.5	76.9	72.4	63.3	68.6	40.4***
Careperson's report of resident's favorite foods							
Knows of one	57.1%	65.1%	71.2%	64.5%	80.0%	54.3%	19.0*
Reports that there are no favorites	34.3	25.4	19.2	14.5	10.0	31.4	
Doesn't know	8.6	9.5	9.6	21.1	10.0	14.3	
Careperson's report of resident's disliked food							
Knows one	29.4%	35.5%	32.7%	39.5%	50.0%	41.2%	16.0
Reports that there are none	66.2	56.5	46.2	48.7	40.0	44.1	
Doesn't know	4.4	8.1	21.2	11.8	10.0	14.7	
Careperson's report of resident's favorite possession							
Knows of one	65.2%	78.5%	57.7%	64.5%	87.1%	79.4%	16.2
Reports that there are none	30.4	20.0	32.7	30.3	12.9	17.6	
Doesn't know	4.3	1.5	9.6	5.3	0.0	2.9	

* $p < .05$
** $p < .01$
*** $p < .001$

Family Contact

Between 54% (foster homes) and 81% (group homes) of residents were reported to have regular contact with a parent or relative. This difference, reported in Table 4.22 was accounted for by the fact that approximately 20% of foster home residents and 12% of ICF-MR residents had no known living relatives to have contact with. About 30% of foster home residents' relatives and 50% of group home residents' relatives lived within one hours drive. Residents were equally likely to visit with relatives at the relative's home as at their own. Among residents who had living relatives, staff reported that 30% to 60% would like more contact, others were satisfied, and practically none wanted less.

Table 4.22

Residents' Involvement with Family and Relatives

Characteristic	Foster		Group		ICF-MR		x^2
	1-4 (N=70)	5-6 (N=68)	1-4 (N=52)	5-6 (N=77)	1-4 (N=31)	5-6 (N=35)	
Regular contact with							
Mother	24.3%	33.8%	46.2%	45.5%	38.7%	48.6%	11.0
Father	20.0	27.9	30.8	28.6	29.0	31.4	2.6
Siblings	22.9	26.5	53.8	37.7	45.2	28.6	17.2**
Other or not specified	21.4	17.6	19.2	24.7	16.1	34.3	5.0
Total one or more	54.3	61.8	80.8	79.2	71.0	74.3	16.5**
Has no known living relative	(23.2)	(19.4)	(3.8)	(6.5)	(16.1)	(8.6)	
Distance from parents or closest relatives							
More than 2 hours	26.1%	23.9%	19.2%	24.7%	12.9%	17.1%	27.2
One to two hours	18.8	25.4	21.2	32.5	29.0	25.7	
Less than 1 hour	21.7	22.4	36.5	24.7	32.3	31.4	
Less than ½ hour	10.1	9.0	19.2	11.7	9.7	17.1	
Total with known relatives	76.8	80.6	96.2	93.5	83.9	91.4	
How often resident visits at relative's homes							
Once per year	11.6%	14.7%	1.9%	13.2%	16.1%	5.7%	57.2***
Several times/year	18.8	8.8	36.5	25.0	35.5	28.6	
Once per month	4.3	4.4	7.7	14.5	6.5	5.7	
More than once/month	7.2	2.9	19.2	17.1	9.7	22.9	
Total who visit at relatives	42.0	30.9	65.4	69.7	67.7	62.9	
How often relatives visit at resident's home							
Once per year	10.1%	14.9%	13.5%	17.1%	6.5%	14.3%	27.6
Several times/year	17.4	14.9	36.5	25.0	25.8	28.6	
Once per month	2.9	6.0	9.6	10.5	6.5	5.7	
More than once/month	2.9	6.0	3.8	9.2	6.5	11.4	
Total whose relatives visit	33.3	41.8	63.5	61.8	45.2	60.0	
Resident's feeling about quantity of contact[1]							
Would like more	38.3%	36.4%	58.3%	53.7%	57.7%	51.7%	15.8
Would like less	0.0	2.3	0.0	1.5	0.0	6.9	
Is satisfied	61.7	61.4	41.7	44.8	42.3	41.4	

[1] Includes only residents with families.

** $p < .01$

*** $p < .001$

Staff and foster parents reported that for one third of residents they felt that more should be done to involve natural families in the lives of residents. In small group homes, staff thought increased communication with the home would help. Large group home and ICF-MR staff thought that "making it easier to visit" would help. Foster parents did not have specific suggestions.

Regarding residents who staff felt would like more family contact than they had at the time (49% of all residents), 20% thought that families' "busy lives" were a factor; 19% attributed transportation or distance as a factor, 15% lack of interest, and for 13% of these residents (6% of all residents) the characteristics or behavior of the residents themselves were believed to limit family contact.

Relationships

A section of the questionnaire assessed residents' friendships (see Table 4.23) after work by Weiss (1974). Foster home residents were least often reported to have a personal friend, defined as someone other than relatives or staff that the resident looked forward to spending time with, although the differences among types and size of facility were not statistically significant. Overall, about 60% of residents had at least one friend. About half of all residents were reported to be satisfied with the number of friends they had, between 10% and 40% of residents wanted more friends; almost no one wanted fewer. It is difficult to understand why respondents reported that 20-30% of residents were "satisfied" with having no friends, other than the friendship that might be provided in their relationship with careproviders. The differences among facilities were not statistically significant, nor were there statistically significant differences among adults who had various levels of retardation, although the proportions were 50% of residents with profound retardation compared to 20-30% of other residents. There was a difference between adults who could talk (19% satisfied with no friends) and those who could not (50%) (X^2 (3) = 19.8; $p < .001$).

About half of all residents were reported to have a particular person to whom they went for help or advice--usually the foster parent, staff or relatives, and in the case of foster homes sometimes other foster family members. Less than one fourth of residents had anyone who depended upon them for help or advice. If they did, it was usually another resident at home or at a day program who was handicapped. Slightly less than half of residents belonged to a group that got together regularly and by which he or she "would be missed" if did not show up.

Table 4.23

Residents' Friendships

Characteristic	Foster 1-4 (N=66)	Foster 5-6 (N=57)	Group 1-4 (N=49)	Group 5-6 (N=68)	ICF-MR 1-4 (N=30)	ICF-MR 5-6 (N=34)	x^2
Number of personal friends							
One	15.2%	10.5%	10.2%	17.6%	13.3%	8.8%	17.9
Two	13.6	14.0	6.1	19.1	16.7	17.6	
3-5	10.6	17.5	24.5	17.6	20.0	23.5	
6 or more	19.7	12.3	20.4	11.8	6.7	23.5	
Total with friend	59.1	54.4	61.2	66.2	56.7	73.5	
Feeling about quantity of friends							
Would like more	9.8%	16.1%	29.2%	34.8%	40.0%	25.8%	24.7
Would like less	0.0	0.0	0.0	1.4	0.0	0.0	
Is satisfied	55.7	55.4	43.8	42.0	40.0	61.3	
Is satisfied with none	34.4	28.6	27.1	21.7	20.0	12.9	
Anyone to whom resident goes for advice or guidance							
Staff/foster parent	26.5%	33.3%	33.3%	38.2%	22.6%	44.1%	32.5*
Careperson's family	11.8	7.9	2.0	0.0	6.5	0.0	
Another resident or friend	1.5	0.0	2.0	2.6	0.0	8.8	
Other	5.9	9.5	5.9	7.9	16.1	2.9	
Total who seek advice	45.6	50.8	43.1	48.7	45.2	55.9	
Anyone who depends on resident for advice or help							
Staff or foster parent	0.0%	3.3%	2.0%	2.7%	6.5%	8.8%	21.8
Another resident or friend	4.4	11.5	13.7	16.2	16.1	17.6	
Friend at day programs	8.8	6.6	7.8	2.7	6.5	0.0	
Other	2.9	3.3	0.0	1.4	0.0	0.0	
Total who give help	16.2	24.6	23.5	23.0	29.0	26.5	
Part of a group that gets together regularly who would miss resident							
Social group or club	3.0%	4.9%	16.0%	3.9%	9.7%	14.7%	3.9
Recreation group	13.4	13.1	12.0	11.8	16.1	11.8	
Church group	23.9	18.0	8.0	19.7	19.4	11.8	
Day program	16.4	9.8	8.0	9.2	3.2	5.9	
Other	3.0	3.3	8.0	7.9	19.4	8.8	
Total 1 or more	44.8	45.9	38.0	47.4	58.1	38.2	
How well resident gets along with other residents at home[1]							
Very well	59.3%	52.4%	33.3%	35.5%	45.2%	47.1%	23.6
Fairly well	25.9	20.6	31.4	27.6	38.7	29.4	
It varies	11.1	23.8	25.5	31.6	12.9	11.8	
Poorly	3.7	3.2	9.8	5.3	3.2	11.8	

[1] Excludes residents in one resident homes

* $p < .05$

** $p < .001$

Table 4.24, which includes only those 62% of sample members who were reported to have at least one friend other than staff or family, summarizes more detailed information about the characteristics of each resident's "best" friend. For 20% of residents with friends, their best friend was their only friend. In all types of residences, most contact between friends was mutually initiated (i.e. sometimes by one resident, sometimes by another). Fifteen percent of residents usually took the initiative themselves, and for 15% of residents the friend took the initiative. A total of 70% of contacts were initiated by the resident, his or her friend, or both. In group homes, where residents tended to be less severely handicapped than residents in foster homes or ICFs-MR, careproviders alone were relatively less likely to initiate contacts between residents and their friends (X^2 (5) = 14.0; $p < .05$).

Most residents' best friends were other (handicapped) residents at home or at a day program, although 10% (large ICF-MR) to 35% (large group home) were reported to have the foster parent or staff person as a best friend.[1] Very few residents (6 of 144 with a friend other than staff or family) had a "best friend" who was not staff or a peer at home or at work. Most best friends were the same age (± 10 years) as residents; about 20% were older and 20% were younger. Most best friends were the same gender as residents (61% for males; 69% for females), and most best friends (with the exception of those in small foster homes and large group homes where staff were often residents' best friends) had handicaps. Friendships in foster homes tended to be of longer duration (more than 40% of best friends having met more than 5 years ago) than in other types of facilities. Because most best friends lived or worked together, they saw each other daily or on weekdays. Twenty-six percent of best friends were reported to see each other weekly or monthly, and 4% less than once per month. Activities varied, but were not significantly different among facility types.

[1]In order to be asked these questions a resident must have had at least one friend who was not a relative or staff person. Given this prerequisite, his/her best friend may have been reported to be a staff person.

Table 4.24

Relationship with Friends Among Residents Who Have Friends

Relationship	Foster		Group		ICF-MR		x^2
	1-4 (N=36)	5-6 (N=30)	1-4 (N=30)	5-6 (N=46)	1-4 (N=16)	5-6 (N=25)	
How resident usually keeps in contact with friends[1]							
Resident (only) initiates	8.3%	6.7%	23.3%	23.9%	6.3%	12.0%	8.6
Friend(s) (only) initiates	19.4	3.3	20.0	15.2	18.8	12.0	4.8
They both initiate contact	38.9	56.7	30.0	43.5	31.3	36.0	5.6
Careprovider (only) initiates	22.2	32.3	12.9	6.5	41.2	24.0	14.0*
Careprovider and residents initiate	25.0	9.7	9.7	30.4	0.0	20.0	12.6*
Other	16.7	10.0	16.7	17.4	0.0	20.0	4.3
Best friend							
Another resident	37.0%	40.0%	46.4%	44.8%	20.0%	50.0%	21.2
A day program peer	29.6	36.0	28.6	20.7	60.0	35.0	
Staff person at res/day	29.6	20.0	17.9	34.5	13.3	10.0	
A volunteer	0.0	0.0	7.1	0.0	6.7	5.0	
A social contact	3.7	4.0	0.0	0.0	0.0	0.0	
Same age as resident	61.8%	60.0%	64.0%	52.8%	70.0%	66.7%	14.9
Ten years older than res.	26.5	25.0	16.0	8.3	30.0	14.3	
Ten years younger than res.	11.8	15.0	20.0	38.9	0.0	19.0	
Same gender as resident							
Male residents	61.1%	71.4%	70.6%	50.0%	0.0%	69.2%	8.9
Female residents	88.2	85.7	75.0	63.2	45.5	37.5	11.9*
Has a handicap	42.9%	74.1%	73.3%	43.9%	80.0%	76.2%	18.0**
How long been friends							
0-2 years	19.4%	26.1%	29.6%	45.9%	14.3%	36.8%	18.6*
3-5 years	32.3	34.8	40.7	35.1	71.4	47.4	
6 or more years	48.4	39.1	29.6	18.9	14.3	15.8	
How often they see each other[1]							
Less than monthly	8.6%	4.0%	0.0%	0.0%	7.1%	4.8%	19.5
Monthly	17.1	12.0	28.6	28.9	14.3	4.8	
Weekly	5.7	8.0	7.1	7.9	7.1	4.8	
Several times per week	17.1	16.0	10.7	7.9	21.4	19.0	
Weekday's	14.3	28.0	14.3	23.7	21.4	38.1	
Daily	37.1	32.0	39.3	31.6	28.6	28.6	
Activities together[1]							
Various recreation	38.2%	32.0%	37.0%	37.8%	14.3%	19.0%	5.1
Dates/social activity	8.8	20.0	25.9	13.5	42.9	14.3	9.5
Church	5.9	12.0	3.7	8.1	0.0	4.8	2.9
Movies	11.8	12.0	14.8	13.5	7.1	23.8	2.5
Visit, talk, "hang out"	50.0	48.0	44.4	51.4	71.4	42.9	3.4
Walks, rides	23.5	24.0	3.7	13.5	21.4	9.5	6.9
Out to eat	11.8	12.0	11.1	24.3	28.6	28.6	5.9
Cards, games	11.8	4.0	3.7	5.4	7.1	4.8	2.4

[1] More than one response may be indicated.

* $p < .05$
** $p < .01$

Although many areas of this study found similarities among residents of the different types of small facilities, questions about neighborhood integration, reported in Table 4.25, identified a number of statistically significant differences between the smaller homes--especially foster homes--and the larger homes. The proportion of residents who had met at least one family in the neighborhood ranged from a low of 60% in large group homes to a high of 87% in small foster homes. One third of small foster home residents had met "many" neighbors compared to less than 10% of those in group homes. Small facilities of every kind seemed to exceed large ones in this regard.

Table 4.25
Neighbors

	Foster		Group		ICF-MR		x^2
	1-4 (N=69)	5-6 (N=64)	1-4 (N=51)	5-6 (N=77)	1-4 (N=31)	5-6 (N=35)	
How many neighbor families has resident met							
One	4.3%	13.6%	17.3%	27.3%	16.1%	14.3%	66.9**
Several	49.3	42.4	38.5	31.2	54.8	37.1	
Many	33.3	22.7	9.6	1.3	9.7	2.9	
Total one or more	87.0	78.8	65.4	59.7	80.6	54.3	
Resident invited to neighbors' homes							
Rarely	10.1%	12.3%	15.7%	14.3%	13.3%	8.8%	44.7**
Sometimes	27.5	12.3	7.8	10.4	10.0	5.9	
Often	13.0	4.6	0.0	0.0	0.0	0.0	
Total	50.7	29.2	23.5	24.7	23.3	14.7	
Residents invited to neighbors without caretaker	24.6%	9.2%	11.8%	7.8%	16.6%	2.5%	6.8
How do neighbors respond to resident							
Hostile or annoyed	2.9%	0.0%	7.8%	2.6%	0.0%	2.9%	54.6**
Avoidance	5.8	12.5	19.6	22.1	19.4	25.7	
Neutral or friendly[1]	49.3	60.9	60.8	55.8	67.7	57.1	
Warm/accepting	39.1	25.0	5.9	9.1	12.9	8.6	
Other	2.9	1.6	5.9	10.4	0.0	5.7	
How do strangers respond to resident							
Hostile or annoyed	0.0%	0.0%	1.9%	0.0%	0.0%	0.0%	40.7*
Avoidance	5.8	16.7	19.2	22.1	22.6	20.0	
Neutral or friendly[1]	71.0	63.6	73.1	64.9	71.0	65.7	
Warm & accepting	21.7	18.2	0.0	5.2	6.5	14.3	
Other	1.4	1.5	5.8	7.8	0.0	0.0	
Particularly positive neighborhood incidents	26.9%	20.6%	15.4%	16.9%	19.4%	22.9%	3.2
Particularly negative neighborhood incidents	7.2%	4.6%	26.9%	13.0%	3.2%	11.4%	19.0*

* $p < .01$
** $p < .0001$
[1] The same as they respond to caretaker.

Foster home residents, especially those in small homes, were also more likely than other facility residents to have been invited into neighbor's homes (51%) and were invited more often. One out of four small foster home residents visited neighbors without the foster parent present, compared to approximately 10% of other groups.

Careproviders reported that most residents were usually responded to by neighbors in a neutral or friendly manner (58%). Between 25% and 39% of foster home residents were said to be treated usually in a warm and accepting manner as compared to about 10% of group home and ICF-MR residents. About 10% of foster home and 20% of group home residents were reported to be avoided. Very few respondents felt the primary reaction to sample members was hostility or annoyance. These patterns were similar as far as strangers in the community were concerned, except that strangers were more likely to be neutral rather than "warm." There were no statistically significant differences between reactions to children and adults.

It was reported that 20% of residents had experienced some particularly positive incidents in the neighborhood, compared to only 11% who had experienced any particularly negative incident. Particularly negative incidents were more likely to be reported for residents of group homes than of foster homes ($p < .01$).

Leisure Activities

Table 4.26 lists twenty-eight leisure activities and the general frequency of participation by sample members. Group home and ICF-MR residents more often wrote letters, went to movies, went shopping, engaged in sports, went for walks, to bars, dances, dates and hair stylists. Foster home residents more often went to church. The much greater tendency for rural living among foster care residents may in part be related to their lower utilization of some activities. But, in general, for most activities the differences among the residents of different types of facilities in their participation in various leisure activities were not statistically significant. However, considerable attention should be given to the proportions of residents in all types of community facilities who were reported to "practically never" participate in the basic leisure activities of the society (e.g., engaging in hobbies, visiting friends,

attending a sporting event). The statistics gathered suggest that for many individuals, participation in typical leisure activities may be considerably less frequent than might be desired, although as will be noted in Chapter 6, not necessarily less frequent than the average for the society as a whole.

Table 4.26

Frequency That Resident Engages in Various Leisure Activities

Activity/frequency	Foster		Group		ICF-MR		x^2
	1-4 (N=60)	5-6 (N=56)	1-4 (N=48)	5-6 (N=76)	1-4 (N=27)	5-6 (N=33)	
Yard/garden work							
Practically never	33.3%	50.0%	56.3%	42.1%	48.1%	42.4%	18.3
Sometimes	36.7	28.6	31.3	34.2	48.1	48.5	
Weekly or more often	30.0	21.4	12.5	23.7	3.7	9.1	
Hobby							
Practically never	40.7%	56.6%	49.0%	33.8%	29.6%	42.4%	16.6
Sometimes	32.2	28.3	28.6	39.4	22.2	24.2	
Weekly or more often	27.1	15.1	22.4	26.8	48.1	33.3	
Radio, records							
Practically never	10.9%	13.6%	12.0%	12.0%	3.4%	11.8%	6.6
Sometimes	21.9	22.0	22.0	20.0	10.3	11.8	
Weekly or more often	67.2	64.4	66.0	68.0	86.2	76.5	
Television							
Practically never	4.8%	8.1%	6.0%	7.8%	0.0%	17.6%	11.6
Sometimes	6.3	9.7	14.0	14.3	13.8	11.8	
Weekly or more often	88.9	82.3	80.0	77.9	86.2	70.6	
Write letters (w. help)							
Practically never	78.3%	70.4%	73.5%	59.5%	70.4%	81.8%	21.2*
Sometimes	21.7	25.9	24.5	31.1	29.6	6.1	
Weekly or more often	0.0	3.7	2.0	9.5	0.0	12.1	
Movies							
Practically never	45.0%	38.6%	24.5%	17.3%	6.9%	12.1%	32.9***
Sometimes	50.0	56.1	61.2	76.0	82.8	84.8	
Weekly or more often	5.0	5.3	14.3	6.7	10.3	3.0	
Meets/clubs/community ctr.							
Practically never	62.1%	50.9%	53.1%	44.4%	26.9%	33.3%	16.3
Sometimes	19.0	27.3	22.4	27.8	50.0	33.3	
Weekly or more often	19.0	21.8	24.5	27.8	23.1	33.3	
Shops							
Practically never	24.6%	24.6%	6.1%	9.5%	14.8%	21.2%	25.7**
Sometimes	54.4	31.6	36.7	50.0	51.9	33.3	
Weekly or more often	21.1	43.9	57.1	40.5	33.3	45.5	
Swims							
Practically never	36.1%	42.9%	38.0%	37.0%	37.9%	17.6%	7.9
Sometimes	39.3	42.9	40.0	39.7	41.4	55.9	
Weekly or more often	24.6	14.3	22.0	23.3	20.7	26.5	

(table continues)

Activity/frequency	Foster		Group		ICF-MR		χ^2
	1-4 (N=60)	5-6 (N=56)	1-4 (N=48)	5-6 (N=76)	1-4 (N=27)	5-6 (N=33)	
Bowls/sports							
Practically never	46.6%	40.4%	40.0%	21.6%	14.3%	15.2%	24.4**
Sometimes	37.9	38.5	30.0	41.9	50.0	48.5	
Weekly or more often	15.5	21.2	30.0	36.5	35.7	36.4	
Cards/games							
Practically never	41.4%	55.1%	46.0%	28.8%	42.3%	39.4%	15.1
Sometimes	37.9	22.4	40.0	47.9	34.6	27.3	
Weekly or more often	20.7	22.4	14.0	23.3	23.1	33.3	
Takes rides							
Practically never	11.1%	5.0%	4.0%	4.0%	0.0%	2.9%	11.1
Sometimes	34.9	31.7	24.0	34.7	25.9	23.5	
Weekly or more often	54.0	63.3	72.0	61.3	74.1	73.5	
Visits friends							
Practically never	36.7%	37.7%	45.8%	39.7%	22.2%	24.2%	15.6
Sometimes	28.3	35.8	29.2	42.5	59.3	42.4	
Weekly or more often	35.0	26.4	25.0	17.8	18.5	33.3	
Entertains friends							
Practically never	54.4%	62.3%	60.0%	59.7%	25.9%	54.5%	15.7
Sometimes	33.3	26.4	32.0	34.7	63.0	30.3	
Weekly or more often	12.3	11.3	8.0	5.6	11.1	15.2	
Sews, crochets, knits							
Practically never	92.9%	84.9%	84.0%	84.5%	77.8%	90.9%	12.3
Sometimes	5.4	11.3	6.0	12.7	11.1	9.1	
Weekly or more often	1.8	3.8	10.0	2.8	11.1	0.0	
Reads							
Practically never	73.7%	61.8%	63.3%	51.4%	48.1%	81.8%	17.1
Sometimes	10.5	18.2	14.3	18.1	29.6	9.1	
Weekly or more often	15.8	20.0	22.4	30.6	22.2	9.1	
Goes to library							
Practically never	73.7%	81.1%	66.0%	54.8%	50.0%	55.9%	17.6
Sometimes	19.3	17.0	26.0	31.5	42.3	35.3	
Weekly or more often	7.0	1.9	8.0	13.7	7.7	8.8	
Goes to park							
Practically never	16.9%	22.8%	16.0%	10.8%	7.1%	0.0%	17.9
Sometimes	72.9	64.9	62.0	66.2	82.1	76.5	
Weekly or more often	10.2	12.3	22.0	23.0	10.7	23.5	
Goes for walk							
Practically never	17.2%	17.2%	12.0%	6.6%	11.1%	0.0%	27.4**
Sometimes	32.8	41.4	22.0	38.2	66.7	47.1	
Weekly or more often	50.0	41.4	66.0	55.3	22.2	52.9	
Active physical exercise							
Practically never	20.0%	19.0%	16.0%	9.1%	11.1%	3.1%	12.9
Sometimes	28.3	25.9	34.0	31.2	22.0	18.8	
Weekly or more often	51.7	55.2	50.0	59.7	66.7	78.1	
Goes to restaurant							
Practically never	15.5%	12.1%	0.0%	12.2%	7.7%	2.9%	12.6
Sometimes	56.9	53.4	57.1	50.0	61.5	55.9	
Weekly or more often	27.6	34.5	42.9	37.8	30.8	41.2	

(table continues)

Activity/frequency	Foster		Group		ICF-MR		x^2
	1-4 (N=60)	5-6 (N=56)	1-4 (N=48)	5-6 (N=76)	1-4 (N=27)	5-6 (N=33)	
Goes to tavern or bar							
Practically never	92.9%			81.9%	85.2%	72.7%	25.4**
Sometimes	3.6	94.4%	78.0%	11.1	11.1	27.3	
Weekly or more often	3.6	3.7	22.0	1.7	3.7	0.0	
		1.9	0.0				
Attends religious service							
Practically never	16.4%			41.3%	25.0%	41.2%	20.6*
Sometimes	23.0	26.8%	40.0%	16.0	32.1	29.4	
Weekly or more often	60.7	28.6	28.0	42.7	42.9	29.4	
		44.6	32.0				
Goes to sporting event							
Practically never	38.6%			34.2%	7.1%	24.2%	16.0
Sometimes	57.9	35.7%	30.6%	53.4	85.7	69.7	
Weekly or more often	3.5	57.1	65.3	12.3	7.1	6.1	
		7.1	4.1				
Attends a party or dance							
Practically never	27.1%	31.5%	14.0%	17.3%	0.0%	9.4%	26.8**
Sometimes	69.5	64.8	78.0	66.7	80.8	84.4	
Weekly or more often	3.4	3.7	8.0	16.0	19.2	6.3	
Goes on a date							
Practically never	94.6%	90.7%	82.0%	72.2%	80.8%	72.7%	23.7**
Sometimes	5.4	9.3	18.0	26.4	19.2	21.2	
Weekly or more often	0.0	0.0	0.0	1.4	0.0	6.1	
Barbershop or beauty salon							
Practically never	14.5%	37.3%	14.0%	12.3%	7.7%	23.5%	26.6**
Sometimes	83.9	59.3	82.0	79.5	92.3	76.5	
Weekly or more often	1.6	3.4	4.0	8.2	0.0	0.0	
Field trip							
Practically never	15.3%	12.3%	26.5%	12.5%	7.7%	5.9%	12.6
Sometimes	74.6	82.5	67.3	76.4	76.9	79.4	
Weekly or more often	10.2	5.3	6.1	11.1	15.4	14.7	

* $p < .05$
** $p < .01$
*** $p < .001$

Table 4.27 shows that approximately 80% of all residents were reported to usually need supervision for leisure activities outside the home. This supervision was reported to be usually provided by a careperson, but for foster home residents also by day program staff. For most leisure activities residents usually went with several other residents (38%) or with *all* other residents as a group (35%). About 10% of residents usually were accompanied by a careprovider alone; 13-15% of foster home residents compared to less than half as many residents in other facilities usually went with friends from

outside the home, and 5% of small foster home residents were reported to usually go with their own families or relatives.

Table 4.27

Supervision and Accompaniment for Leisure Activities

	Foster		Group		ICF-MR		x^2
	1-4 (N=66)	5-6 (N=62)	1-4 (N=51)	5-6 (N=76)	1-4 (N=28)	5-6 (N=34)	
Does resident usually need supervision for outside leisure activities							
By careperson	47.0%	64.5%	70.6%	69.7%	75.0%	76.5%	42.9**
By day program	15.2	4.8	2.0	2.6	0.0	0.0	
By recreation program	1.5	6.5	2.0	5.3	3.6	0.0	
Other or yes but not specified	16.7	9.7	3.9	1.3	3.6	11.8	
Total	80.3	85.5	78.4	78.9	82.1	88.2	
Who usually joins resident in outside leisure activities							
Alone	7.5%	1.6%	5.9%	6.5%	0.0%	0.0%	65.7***
With several other residents	23.9	37.1	35.3	49.4	22.6	62.9	
With all residents as a group	28.4	35.5	39.2	37.7	54.8	20.0	
With careprovider alone	13.4	11.3	11.8	1.3	19.4	8.6	
With outside friends	14.9	12.9	2.0	2.6	0.0	5.7	
With own family/relatives	4.5	0.0	3.9	2.6	0.0	2.9	
Other	7.5	1.6	2.0	0.0	3.2	0.0	
Residents who have regular social contact with non-handicapped people other than staff or family	55.1%	59.4%	48.0%	41.1%	22.6%	45.7%	14.2*
Transportation used for leisure activities							
None needed	0.0%	0.0%	1.9%	1.3%	0.0%	0.0%	3.2
Walks	22.1	17.2	28.8	28.6	25.8	42.9	8.7
Car/van from residence	92.6	89.1	100.0	88.3	93.5	100.0	10.7
Special van from other agency	23.5	35.9	9.6	18.2	12.9	0.0	24.8***
Public transport	17.6	9.4	5.8	10.4	16.1	17.1	5.8
Other	5.9	0.0	1.9	5.2	0.0	2.9	6.2

* $p < .05$
** $p < .01$
*** $p < .001$

Slightly less than half of all residents, most often foster home residents, were reported to have regular social contact with non-handicapped people other than staff or family. One third of residents had this contact in church, 22% through family, friends, and present or former staff, 12% through neighbors, and 16% through leisure activities and outings. Virtually all facilities had a car or van used for transportation for leisure activities; residents also walked, used public transportation, and especially in foster homes used special transportation provided by another agency (X^2 (5) = 24.8; $p < .0001$).

Carepersons were asked about their impression of the amount of free time residents had at home. As shown in Table 4.28, most (84%) thought the amount of free time was about right, while a few thought there was too little free time, and 13% thought there was too much. Carepersons in group homes and ICFs-MR were more likely than foster parents (X^2 (5) = 18.3; $p < .01$) to report that there were additional leisure activities that resident would like to do. For these 31% of all residents, ranging from 18% in large foster homes to 46% in large group homes, the most common problem was that the resident lacked money or that activity was not available. Twenty-one percent of the residents thought to be desiring additional activities (i.e., 7% of all residents) were limited in participation because they lacked someone to accompany him or her. This was most often considered a problem in group homes and large ICFs-MR (X^2 (5) = 14.1; $p < .05$).

Table 4.28

Amount of Free Time

	Foster		Group		ICF-MR		x^2
	1-4 (N=66)	5-6 (N=62)	1-4 (N=51)	5-6 (N=76)	1-4 (N=28)	5-6 (N=34)	
Careproviders impression about residents' free time at home							
Too little	3.0%	3.2%	5.8%	5.3%	3.2%	0.0%	9.2
About right	84.8	85.7	71.2	85.3	87.1	88.6	
Too much	12.1	11.1	23.1	9.3	9.7	11.4	
Residents who would like more activities	22.4%	18.3%	25.0%	45.8%	45.2%	35.3%	18.3**
For residents who would like to do more, what prevents these activities							
Resident lacks transportation	6.7%	0.0%	16.7%	21.2%	21.4%	25.0%	3.9
Resident lacks money	26.7	11.1	33.3	27.3	42.9	16.7	3.8
Activity not available	53.3	11.1	41.7	6.1	21.4	41.7	17.2**
Lack of skill	6.7	33.3	8.3	15.2	28.6	0.0	7.9
Lack of time	20.0	11.1	8.3	30.3	7.1	25.0	5.3
Distance	13.3	0.0	16.7	12.1	0.0	33.3	8.2
Problem behavior	6.7	11.1	16.7	21.2	14.3	25.0	2.4
No one to accompany res.	0.0	11.1	33.3	30.3	0.0	41.7	14.1*
Other	20.0	11.1	8.3	24.2	21.4	16.7	1.9

* $p < .05$
** $p < .01$

Individual Habilitation Plans

Tables 4.29 and 4.30 present information about residents' individual habilitation plans. In the area of self care skills (eating, dressing, bathing and toileting) there were no statistically significant

differences among facility types with regard to the proportions of residents who had specific goals, how they were being taught, or what added steps staff thought should be taken to attain them. Twenty-three percent of residents had informal self-care goals; 49% formal goals that were part of a written plan. For residents with goals, 87% received special training at home; 44% at their day program. For 28% of residents with self care goals, respondents thought that more could be done to teach self care--13% thought the day program should do more; 10% felt that they would benefit from a special consultation from an expert regarding this specific resident.

Table 4.29

Resident Goals in Self-Care Skills

	Foster		Group		ICF-MR		x^2
	1-4 (N=66)	5-6 (N=59)	1-4 (N=52)	5-6 (N=76)	1-4 (N=31)	5-6 (N=35)	
Is learning self-care skills a goal for this resident[1]							
Yes, an informal goal	30.3%	13.6%	28.8%	21.1%	22.6%	22.9%	10.9
Yes, part of a written plan	39.4	49.2	48.1	51.3	51.6	60.0	
Total	69.7	62.7	76.9	72.4	74.2	82.9	
For residents with self-care goals, what is being done?[2]							
Special training at residence	74.5%	92.5%	92.3%	87.0%	90.9%	92.9%	9.9
Special training at day prog.	57.4	50.0	38.5	31.5	45.5	46.4	8.0
Nothing special at home or day prog.	4.3	2.5	5.1	3.7	4.5	0.0	1.6
For residents with self-care goals, what added steps could be taken to teach self-care[2]							
More training at day prog.	15.6%	12.5%	10.0%	13.2%	13.6%	10.7%	0.7
Carepersons need more training	4.4	2.5	15.0	13.2	13.6	0.0	10.0
Need more staff	4.4	5.0	5.0	5.7	0.0	10.7	3.0
Need special consultation	8.9	7.5	10.0	13.2	9.1	10.7	1.0
Total 1 or more	26.7	26.8	27.5	30.2	31.8	28.6	0.3

[1] "Not sure" coded same as no.

[2] More than one response may have been indicated.

Community living skills (e.g., making a bed, doing laundry, preparing meals, using the phone, taking the bus, buying groceries, or using a checkbook) were more often goals for group home residents (75%) than for foster home residents (45%); X^2 (10) = 41.7; $p < .0001$). For residents with goals, there were no differences as to where training was carried out. Group home and ICF-MR staff

were somewhat more likely than foster parents to report that added steps could be taken to help residents learn community living skills (about 40% compared to 20%), both in terms of a need for more staff training (X^2 (5) = 11.7; $p < .05$) and for more staff (X^2 (5) = 14.2; $p < .05$).

Table 4.30

Resident Goals in Community Living Skills

	Foster		Group		ICF-MR		X^2
	1-4 (N=67)	5-6 (N=61)	1-4 (N=52)	5-6 (N=75)	1-4 (N=30)	5-6 (N=35)	
Is learning community living skills a goal for this resident[1]							
Yes, an informal goal	20.9%	9.8%	17.3%	29.3%	10.0%	22.9%	41.7**
Yes, part of a written plan	26.9	31.1	61.5	44.0	60.0	54.3	
Total	47.8	41.0	78.8	73.3	70.0	77.1	
For residents with community living goals, what is being done?[2]							
Special training at residence	71.9%	81.5%	89.7%	84.3%	77.3%	91.3%	5.8
Special training at day program	59.4	63.0	35.9	47.1	36.4	39.1	8.2
Nothing special at home or day	6.3	0.0	2.6	3.9	0.0	0.0	3.9
For residents with community living goals, what added steps could be taken to help resident learn?[2]							
More training at day program	23.5%	11.1%	9.8%	24.5%	14.3%	8.0%	7.0
Carepersons need more training	3.0	0.0	17.1	13.2	14.3	0.0	11.7*
Need more staff	3.0	3.7	2.4	18.9	23.8	16.0	14.2*
Need special consultation	6.1	10.7	9.8	17.0	9.5	0.0	6.3
Total one or more	24.2	18.5	36.6	50.9	57.1	32.0	14.5*

[1] "Not sure" coded same as no.
[2] More than one response may have been indicated.
* $p < .05$
** $p < .0001$

In the early section of the careperson questionnaire that assessed adaptive behavior, carepersons were asked about the level of assistance *needed* by residents (see Table 4.4). In a later section of the questionnaire that asked about resident's habilitation plans, respondents were asked how much assistance was routinely provided to residents. In the areas of self-care skills (eating, dressing, bathing and toileting), among all types of facilities and all 4 self-care areas, the exact agreement between assistance required (4 levels) and that received (4 levels) was 82%, with most

disagreements involving "independent" residents whose "assistance" was in the form of verbal reminders. There were no statistically significant differences among facility types.

In the area of community living skills (see Table 4.5) the exact correspondence between assistance needed (5 levels) and assistance received (8 levels) ranged from 50% (buying groceries) to 76% (making bed), with no statistically significant differences among facility types. Correspondence here was somewhat lower than in the self-care area because for 42% of residents there was at least one area which staff reported a resident was not expected to perform (e.g., 22% of residents were not expected to buy groceries). Only 5% of residents had any area in which assistance was not received because they needed "too much help," and only 2% because they refused to participate or cooperate. There were no statistically significant differences by type or size of residential setting.

CHAPTER 5

PROGRAM CHARACTERISTICS

This chapter presents findings of the study regarding basic services and programs received by the residents of small community living arrangements. Among the services and programs studied were case management, program planning, day and vocational services and special support services.

Case Management

As shown in Table 5.1 almost all the individuals in the resident sample were reported to have case managers. A somewhat lower percentage of residents of group homes was reported to have case managers (approximately 85%).

Table 5.1

Proportion of Residents Who Had Case Managers

Case Manager	Foster		Group		ICF-MR		x^2
	1-4 (N=68)	5-6 (N=67)	1-4 (N=52)	5-6 (N=73)	1-4 (N=31)	5-6 (N=35)	
Yes	94.1%	100.0%	84.6%	89.0%	100.0%	94.3%	
No	5.9	0.0	15.4	11.0	0.0	5.7	15.45*
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

The organizational affiliation of case managers assigned to residents of these facilities is summarized in Table 5.2. Review of this table indicates a significant relationship between organization affiliation and type of placement (X^2 (25) = 144.66, $p < .01$). For foster homes, the largest single affiliation was a state agency. The next most common affiliations were regional and county agencies. In the case of group homes, the largest single affiliation was that of the county service agency, with the next most common response being a state agency. The pattern of affiliations for case managers assigned to ICFs-MR was somewhat different. The responses seemed to be approximately equally divided between state agencies and the residential provider itself. Across facility types, the most predominant affiliation for case managers were state, county, regional, and the residential providers.

Table 5.2

Organization Which Provides Case Manager

Organization	Foster		Group		ICF-MR		x^2
	1-4 (N=64)	5-6 (N=68)	1-4 (N=44)	5-6 (N=64)	1-4 (N=27)	5-6 (N=33)	
County	10.9%	20.6%	59.1%	25.0%	7.4%	42.4%	
Region	15.6	36.8	4.5	14.1	3.7	24.2	
State	70.3	42.6	15.9	34.4	37.0	12.1	144.66*
Other	1.6	0.0	0.0	3.1	3.7	9.1	
This home/facility	1.6	0.0	18.2	18.8	48.1	12.1	
School, day program	0.0	0.0	2.3	4.7	0.0	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

One of the most important issues in the field of developmental disabilities is the extent to which persons receive active case management services in residential and other service programs. Table 5.3 presents information on the frequency of visits by case managers. Approximately half of all foster home residents were reported to be visited monthly. The vast majority of individuals received a visit by a case

Table 5.3

Frequency of Visit by Case Manager

Frequency	Foster		Group		ICF-MR		x^2
	1-4 (N=64)	5-6 (N=68)	1-4 (N=44)	5-6 (N=65)	1-4 (N=30)	5-6 (N=33)	
Never	0.0%	0.0%	6.8%	4.6%	0.0%	3.0%	
Weekly	4.7	0.0	13.6	21.5	30.0	30.3	
Monthly	43.8	54.4	34.1	33.8	53.3	21.2	82.32*
Every 3 months	35.9	41.2	27.3	20.0	10.0	21.2	
Twice yearly	7.8	4.4	13.6	10.8	3.3	18.2	
Once yearly	6.3	0.0	4.5	1.5	0.0	0.0	
Other	1.6	0.0	0.0	7.7	3.3	6.1	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

manager at least once every three months. Approximately 15% of the individuals received visits from case managers every six months or even less frequently.

A second indication of the intensity of case management services was the reported average length of visits by case managers, reported in Table 5.4. The most common responses were in the range of thirty minutes to one hour. Visits averaging more than one hour per visit were also commonly reported. Thus, the typical case manager visited each resident approximately every one to three months for 30 to 60 minutes.

Table 5.4

Length of Each Visit by Case Manager

Length of Time	Foster		Group		ICF-MR		x^2
	1-4 (N=64)	5-6 (N=68)	1-4 (N=40)	5-6 (N=60)	1-4 (N=31)	5-6 (N=32)	
15 minutes or less	1.6%	1.5%	7.5%	10.0%	6.5%	0.0%	
16-30 minutes	17.2	13.2	22.5	25.0	3.2	18.8	
30 minutes to one hour	48.4	51.5	42.5	36.7	35.5	65.6	29.75*
More than one hour	32.8	33.8	27.5	28.3	54.8	15.6	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .05$

Data in Table 5.5 indicate that most of respondents received some form of contact in addition to face-to-face visits. Most of the contacts other than direct visits were through the use of phone calls.

Table 5.5

Additional Types of Contact Between the Respondent and the Case Manager

Types of Contact	Foster		Group		ICF-MR	
	1-4 (N=64)	5-6 (N=65)	1-4 (N=42)	5-6 (N=63)	1-4 (N=32)	5-6 (N=32)
Letters	5.4%	23.8%	2.7%	10.8%	3.5%	23.4%
Phone	65.2	56.4	53.6	54.1	80.5	50.8
Other	9.1	15.2	8.0	14.4	3.5	3.9
None	20.3	4.6	35.7	20.6	12.5	21.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

A further review of responses on other types of contacts indicated that most of the contacts by phone and written correspondence occurred at least once a month.

Additional analyses were conducted to assess the functioning of case managers in these residential facilities. One question asked about the extent to which respondents felt the case manager had a clear understanding of the resident's needs, abilities, and problems (see Table 5.6). There are clear differences in the pattern of responses by facility type on this question (X^2 (10) = 25.95, $p < .01$). Foster parents generally felt that case managers understood the resident's needs, abilities, and problems very well. ICF-MR respondents also indicated a relatively high degree of understanding by case managers of the needs, abilities, and problems of residents. Somewhat less favorable ratings were given by group homes. Few case managers were given extremely low ratings on this question (less than 5%).

Table 5.6

Careperson Opinion About the
Degree of Case Manager's Understanding of Resident's Needs, Abilities and Problems

Degree of Understanding	Foster		Group		ICF-MR		x^2
	1-4 (N=65)	5-6 (N=68)	1-4 (N=44)	5-6 (N=64)	1-4 (N=32)	5-6 (N=33)	
Very well	75.4%	80.9%	50.0%	57.8%	78.1%	57.6%	
Somewhat	20.0	19.1	40.9	37.5	15.6	42.4	25.95*
Not at all	4.6	0.0	9.1	4.7	6.3	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Table 5.7 presents information about the percentage of case managers performing various functions for residents and staff. While there are some differences across types of facilities, the pattern of responses was relatively similar. The primary differences by facility type occurred between group homes versus foster homes and ICFs-MR. Group home respondents generally indicated less frequent provision of the various service functions than was noted by respondents from the other two types of residential facilities. Most of the functions performed were directly related to the needs of the residents of the various facilities. Relatively little time was devoted by case managers to providing direct technical assistance to providers, except in the matter of assisting them with paperwork responsibilities.

Table 5.7

Case Manager Activities, as Reported by Carepersons

Type of Work	Foster		Group		ICF-MR	
	1-4 (N=63)	5-6 (N=63)	1-4 (N=40)	5-6 (N=63)	1-4 (N=30)	5-6 (N=33)
Asks about the resident's situation when visiting	96.8%	98.4%	95.0%	92.1%	83.3%	97.0%
Asks about the resident's problems	93.7	92.1	95.0	85.7	83.3	93.9
Offers help for resident's problems	82.5	81.0	60.0	68.3	76.7	60.6
Examines each aspect of the resident's program plan during the visit	66.7	65.1	52.5	36.5	43.3	63.6
Talks to the resident during the visit	77.8	76.2	72.5	73.0	86.7	57.6
Checks on the resident's behavior in the school or day program	81.0	74.6	50.0	61.9	76.7	75.8
Provides training and advice on how to meet the resident's needs more effectively	55.6	52.4	25.0	42.9	53.3	45.5
Arranges special support/training program for the provider and the residents	58.7	77.8	55.0	50.8	76.7	78.8
Arranges special support/training for the provider when needed	36.5	38.1	12.5	27.0	36.7	18.2
Help solve problems that the provider cannot manage	61.9	79.4	55.0	41.3	66.7	54.5
Assists with paperwork	49.2	68.3	47.5	58.7	66.7	84.8
Other	1.6	3.2	2.5	11.1	6.7	9.1

Note. Columns do not total 100% because respondents could select more than one alternative.

Program Planning

Tables 5.8 and 5.9 present information on the availability of written plans, including goals and objectives for persons residing in these facilities. Nearly all residents had written plans of goals and objectives. In the small foster homes, however, approximately 10% of the respondents reported that plans did not exist or that they were unaware of the availability of written plans. The extent of careprovider's involvement in program planning was similar in all facilities in this study, with reported rates of involvement by respondents of approximately 90% or more. Small foster home careproviders

participated in planning meetings, but were less likely to actively develop goals and program objectives than were staff in other types of facilities.

Table 5.8

Written Plan of Goals or Objectives for the Resident

Written Plan	Foster		Group		ICF-MR		x^2
	1-4 (N=68)	5-6 (N=66)	1-4 (N=52)	5-6 (N=74)	1-4 (N=32)	5-6 (N=35)	
No, or unknown to respondent	13.2%	6.1%	1.9%	4.1%	0.0	2.9%	
Yes; or have a copy of school or day program's	86.8	93.9	96.2	90.5	96.9	97.1	20.16*
Other	0.0	0.0	1.9	5.4	3.1	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .05$

Table 5.9

How the Respondent Is Involved in the Development of the Resident's Individual Care Plans

Type of Involvement	Foster		Group		ICF-MR	
	1-4 (N=63)	5-6 (N=46)	1-4 (N=47)	5-6 (N=70)	1-4 (N=24)	5-6 (N=29)
Sit in on planning meetings	32.3%	30.4%	17.0%	18.6%	50.0%	31.0%
Develop.goals/obj. or program	7.7	28.3	55.3	35.7	25.0	31.0
Any input, phone, etc.	23.1	15.2	14.9	27.1	16.7	27.6
Implement plan	10.8	13.0	8.5	4.3	0.0	6.9
Other	6.2	0.0	2.1	4.3	8.3	0.0
Not involved	6.2	4.3	0.0	5.7	0.0	0.0
No plan	13.8	8.7	2.1	4.3	0.0	3.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

The reported frequency of revising written program plans is summarized in Table 5.10. The most frequently reported period for revising program plans was yearly. The group home and ICF-MR respondents reported more frequent revisions, with revisions reported every six months or less in at least 50% of the cases. There was a tendency for foster homes, particularly smaller homes of 1-4 persons, to revise program plans somewhat less frequently than the other respondent groups.

Table 5.10

Frequency of Revision on the Resident's Written Plan

Frequency	Foster		Group		ICF-MR		x^2
	1-4 (N=65)	5-6 (N=64)	1-4 (N=49)	5-6 (N=73)	1-4 (N=32)	5-6 (N=35)	
Yearly	72.3%	56.3%	38.8%	35.6%	34.4%	51.4%	
Every 6 months	6.2	12.5	14.3	27.4	25.0	11.4	
Quarterly	13.8	25.0	36.7	32.9	15.6	31.4	55.51*
Monthly	1.5	6.3	4.1	2.7	18.8	2.9	
Other	6.2	0.0	6.1	1.4	6.3	2.9	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Table 5.11 presents information on whether the written program plan identified a certain planned length of stay at the facility, and included a subsequent placement plan. For more than 50% of residents in all categories it was indicated that there was no planned length of stay or recommendation for a new placement in the program plan. When such plans were noted, the foster home respondents were more likely to indicate age as being a requirement for movement to a new placement than was

Table 5.11

Notation of Length of Stay and Displacement Recommendation in Resident Plan

Displacement Plan	Foster		Group		ICF-MR	
	1-4 (N=70)	5-6 (N=68)	1-4 (N=53)	5-6 (N=78)	1-4 (N=32)	5-6 (N=35)
N/A, no plan	10.0%	6.3%	5.8%	6.8%	6.7%	0.0%
No mention of future move	77.4	64.4	71.4	56.5	57.1	57.1
Yes, when resident reaches a certain age	25.8	35.5	7.7	11.6	0.0	4.5
Yes, when resident attains certain skills	16.1	25.8	42.3	44.2	44.4	54.5
Yes, depending on behavior	9.7	3.2	7.7	20.9	11.1	27.3
Yes, other goal or reason	6.5	6.5	11.5	9.3	16.7	13.6
The plan indicates that they will always be here	12.9	3.2	3.8	9.3	11.1	0.0

Note. Columns do not total 100% because respondents could select more than one alternative.

true of respondents from group homes and ICFs-MR. The most commonly mentioned reason for possible alternative placements for group home and ICF-MR residents was related to the attainment of certain adaptive behavior skills. Within the group homes, approximately 40-55% of the recommended placements were associated with attainment of increased skill levels.

Day and Vocational Programs

Table 5.12 presents information on residents' daytime developmental and vocational program activities. At least 90% of all persons living in these facilities attended some structured daytime program outside of the residential facility. The rates of participation for residents in group homes and ICFs-MR exceeded 95%. There was a significant difference among facility and size groupings on the types of resident daytime activities (X^2 (25) = 65.94, $p < .01$). Foster home residents were somewhat more likely (approximately 10% of the residents) to stay at home without a structured daytime activity (some of these residents were preschool age or very old). The most common single placements were day activity center and sheltered workshop programs.

Table 5.12

Activities or Programs the Resident Engages in Regularly During Weekday Hours

Activities/Programs	Foster		Group		ICF-MR		x^2
	1-4 (N=70)	5-6 (N=68)	1-4 (N=51)	5-6 (N=77)	1-4 (N=32)	5-6 (N=35)	
Resident stays home	10.0%	10.3%	2.0%	0.0%	3.1%	0.0%	
Day activity center	31.4	25.0	17.6	15.6	37.5	37.1	
Work activity placement	8.6	7.4	25.5	18.2	9.4	5.7	
Sheltered workshop	21.4	22.1	41.2	51.9	37.5	28.6	65.94*
On-the-job training	1.4	0.0	2.0	1.3	0.0	2.9	
School	27.1	35.3	11.8	13.0	12.5	25.7	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Sheltered workshops were particularly common placements for residents in group homes and in ICFs-MR. Foster home residents were somewhat more likely to attend day activity centers. A fairly

large percentage of residents in all settings were reported to go to school. Fifty of the total of 72 residents who attended school attended special schools rather than special classes in regular schools. Few individuals were in work-training or community job-training placements. Only one resident in the entire sample was cited as competitively employed with regular pay and with non-disabled workers.

The extent of participation in outside day programs is summarized in Table 5.13. Virtually all residents who participated in structured day programs did so five days per week. The number of hours per day spent in day programs is summarized in Table 5.14. Although there are slight differences by facility type, the vast majority of residents spend at least five hours per day in structured daytime programs.

Table 5.13

Number of Days Per Week the Resident Attends Day Program

Number of Days Per Week	Foster		Group		ICF-MR		χ^2
	1-4 (N=57)	5-6 (N=55)	1-4 (N=50)	5-6 (N=73)	1-4 (N=31)	5-6 (N=35)	
Less than five days	0.0%	9.1%	2.0%	2.7%	3.2%	2.9%	
Five or more days	100.0	90.9	98.0	97.3	96.8	97.1	8.03
Total	100.0	100.0	100.0	100.0	100.0	100.0	

Table 5.14

Number of Hours Per Day the Resident Attends Day Program

Number of Hours	Foster		Group		ICF-MR		χ^2
	1-4 (N=60)	5-6 (N=57)	1-4 (N=51)	5-6 (N=76)	1-4 (N=29)	5-6 (N=35)	
Four hours or less	5.0%	0.0%	0.0%	2.6%	3.4%	0.0%	
Five to seven hours	76.7	89.5	78.4	71.1	75.9	85.7	12.75
Eight hours or more	18.3	10.5	21.6	26.3	20.7	14.3	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

The distance and the amount of travel time between the residential and daytime programs are summarized in Table 5.15. Most programs were located within ten miles of the person's

residence. The amount of commuting time from the individual's home to the day program placement was generally less than 30 minutes. Most of the transportation for individuals attending day programs was provided by the day program or another outside agency providing special transportation (see Table 5.16).

Table 5.15

Distance and Amount of Travel Time Between Home and Day Program

Distance/Travel Time	Foster		Group		ICF-MR		x^2
	1-4 (N=65)	5-6 (N=61)	1-4 (N=52)	5-6 (N=71)	1-4 (N=31)	5-6 (N=34)	
Distance							
1-10 miles	54.7%	65.6%	84.6%	84.5%	92.6%	58.8%	
11-20 miles	25.0	14.8	13.5	12.7	0.0	26.5	36.19*
21-55 miles	20.3	19.7	1.9	2.8	7.4	14.7	
Total	100.0	100.0	100.0	100.0	100.0	100.0	
Amount of Travel Time							
30 minutes or less	43.1%	53.3%	78.8%	91.2%	77.4%	52.9%	
30 to 60 minutes	29.2	18.3	11.5	7.4	16.1	41.2	62.10*
More than one hour	27.7	28.3	9.6	1.5	6.5	5.9	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Table 5.16

Provider of Transportation to the Day Program

Provider	Foster		Group		ICF-MR		x^2
	1-4 (N=58)	5-6 (N=59)	1-4 (N=50)	5-6 (N=74)	1-4 (N=30)	5-6 (N=33)	
The respondent	8.6%	5.1%	32.0%	17.6%	43.3%	21.2%	
Resident walks/rides bike	3.4	1.7	6.0	9.5	0.0	3.0	
Public transportation	8.6	13.6	14.0	9.5	10.0	18.2	52.72*
Provided by day program	58.6	50.8	32.0	36.5	36.7	42.4	
Provided by another agency	20.7	28.8	12.0	23.0	10.0	15.2	
Other	0.0	0.0	4.0	4.1	0.0	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Table 5.17 provides information on the number of weeks per year the day program was closed for vacations and other reasons. The extent of closure varied substantially across program types (X^2 (15) = 50.76, $p < .01$). There is a tendency for day programs of residents in foster homes to be closed for somewhat greater lengths of time than was true of the other two residential program placements. However, most of the programs were operational for at least eleven months out of each year. The respondents were also asked whether residents of their facilities took additional time off for vacations, visitations to family, and other purposes. More than 50% of the respondents reported that individuals living in their facilities took one or two extra weeks off each year. Residents' total time off per year is also summarized in Table 5.17. Although the amount

Table 5.17

Number of Weeks Per Year the Day Program Is Closed, and Residents' Additional/Total Weeks Off Per Year

Number of Weeks Off	Foster		Group		ICF-MR		x^2
	1-4 (N=57)	5-6 (N=59)	1-4 (N=50)	5-6 (N=72)	1-4 (N=29)	5-6 (N=34)	
Number of Weeks Day Program Closed							
None	27.3%	26.8%	42.0%	23.9%	66.7%	8.8%	
One to two weeks	23.6	26.8	36.0	36.6	14.8	58.8	50.76*
Three to four weeks	16.4	23.2	20.0	19.7	7.4	11.8	
Five or more weeks	32.7	23.2	2.0	19.7	11.1	20.6	
Total	100.0	100.0	100.0	100.0	100.0	100.0	
Residents' Extra Weeks Off							
None	35.1%	25.4%	42.0%	45.8%	41.4%	32.4%	
One to two weeks	57.9	64.4	52.0	48.6	51.7	61.8	19.34
Three to four weeks	7.0	10.2	2.0	5.6	6.9	5.9	
Five weeks or more	0.0	0.0	4.0	0.0	0.0	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	
Total Weeks Off							
None	5.7%	1.8%	8.2%	11.6%	28.0%	0.0%	
One to two weeks	30.2	34.5	53.1	31.9	44.0	27.3	
Three to four weeks	15.1	21.8	28.6	30.4	12.0	42.4	55.38*
Five to eight weeks	24.5	29.1	8.2	14.5	4.0	15.2	
Nine or more weeks	24.5	12.7	2.0	11.6	12.0	15.2	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

of total time off due to various reasons varied substantially across settings (X^2 (20) = 55.38, $p < .01$), the majority of residents in all facility and size groups had a total of less than four weeks off each year.

Some questions were posed to careproviders about the extent to which the residents appeared to enjoy their day program placements, although obviously the answers to such questions were quite subjective (see Table 5.18). Approximately 85% of the individuals living in these facilities were thought by respondents to enjoy their day programs. The reasons given for enjoying or not enjoying the day program are listed in Table 5.19. The most frequent responses given for positive evaluations of day program placements had to do with the enjoyment of being with other people and friends, and enjoyment of activities provided by the day program. The more negative responses regarding day programs were highly varied and included too much work, dislike for activities, and difficulties with staff and peers.

Table 5.18

Degree of Resident's Enjoyment in Going to His/Her Day Program

Degrees of Enjoyment	Foster		Group		ICF-MR		x^2
	1-4 (N=57)	5-6 (N=52)	1-4 (N=49)	5-6 (N=72)	1-4 (N=30)	5-6 (N=31)	
Likes it	93.0%	96.2%	67.3%	77.8%	86.7%	80.6%	
Somewhat likes it	1.8	1.9	14.3	12.5	6.7	12.9	28.56*
Doesn't like it	5.3	0.0	16.3	9.7	6.7	3.2	
Other	0.0	1.9	2.0	0.0	0.0	3.2	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .05$

Table 5.19

Reasons for Resident's Enjoying/Not Enjoying the Day Program

Reason	Foster		Group		ICF-MR		x^2
	1-4 (N=45)	5-6 (N=35)	1-4 (N=42)	5-6 (N=61)	1-4 (N=27)	5-6 (N=31)	
Lots of people, socialize	24.4%	11.4%	23.8%	13.1%	29.6%	22.6%	
Likes activities (learning, stimulation, work)	35.6	48.6	16.7	26.2	11.1	32.3	
Friends	26.7	20.0	11.9	8.2	11.1	22.6	
Likes the money	2.2	5.7	7.1	18.0	11.1	6.5	81.24*
Too much work	0.0	0.0	4.8	1.6	0.0	0.0	
Doesn't like activities, or not enough	0.0	0.0	11.9	4.9	7.4	0.0	
Prefer something else	2.2	0.0	2.4	4.9	3.7	3.2	
Like staff	4.4	0.0	2.4	1.6	18.5	3.2	
Schedule, keeps busy	0.0	8.6	4.8	9.8	3.7	9.7	
Peer group	0.0	0.0	2.4	1.6	0.0	0.0	
Other	4.4	5.7	11.9	9.8	3.7	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Respondents were asked to indicate the extent of contact they had with personnel of day programs (see Table 5.20). There was a somewhat greater tendency for personnel in group homes and ICF-MR group homes to have more contact with day program personnel than foster parents. But across all facility types, respondents indicated rather frequent contact with day program personnel. Monthly or more frequent contact was reported by approximately 55-75% of respondents, depending on facility type. Reasons reported for contacts between respondents and day program staff are shown in Table 5.21. These responses were varied, with statistically significant differences among respondents from different types of facilities (X^2 (40) = 65.44, p = .01). Many reasons obviously derived from the characteristics and perceived needs of residents. A rather substantial number of such mentions dealt with the management of problem behaviors. Activities, arrangements, and logistics also were frequently mentioned topics in these consultations. Another frequent reason for contact involved discussions to assess the progress of individuals as well as to schedule meetings, develop plans, goals, and objectives

for individualized program plans. Data shown in Table 5.20 and 5.21 suggest that residential and day program personnel maintained reasonably close contact on a wide range of issues related to the behavioral training and other needs of persons with mental retardation living in these facilities.

Table 5.20

Frequency of Contact Between Careperson and Staff From Day Program

Frequency of Contact	Foster		Group		ICF-MR		x^2
	1-4 (N=59)	5-6 (N=58)	1-4 (N=51)	5-6 (N=75)	1-4 (N=28)	5-6 (N=35)	
About every day	8.5%	12.1%	19.6%	18.7%	39.3%	22.9%	
About once a week	25.4	34.5	31.4	26.7	21.4	20.0	
About once a month	22.0	15.5	21.6	25.3	14.3	22.9	25.98
Several times a year	37.3	34.5	21.6	21.3	25.0	22.9	
Once a year or less	6.8	3.4	5.9	8.0	0.0	11.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

Table 5.21

Most Common Reason for Contacts Between Careperson and Day Program Staff

Reason	Foster		Group		ICF-MR		x^2
	1-4 (N=56)	5-6 (N=49)	1-4 (N=45)	5-6 (N=64)	1-4 (N=24)	5-6 (N=32)	
Behavior problems	12.5%	12.2%	24.4%	20.3%	16.7%	15.6%	
Activities	3.6	18.4	2.2	3.1	0.0	12.5	
Other problems	8.9	14.3	15.6	7.8	16.7	21.9	
Logistics	12.5	10.2	2.2	17.2	20.8	12.5	
Plans/goals of teaching/training	14.3	22.4	6.7	10.9	4.2	12.5	65.44*
Progress	23.2	16.3	35.6	25.0	16.7	6.3	
Injuries (health)	8.9	2.0	4.4	1.6	12.5	3.1	
Social/other	5.4	4.1	6.7	9.4	0.0	6.3	
Meetings	10.7	0.0	2.2	4.7	12.5	9.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

* $p < .01$

Finally, respondents were asked whether they felt knowledgeable about the day program activities and placements of persons in their facilities (see Table 5.22). Approximately 85% of the individuals felt that they had a good knowledge about the day program activities of persons living in their homes.

Table 5.22

Whether the Careperson Feels He/She Knows Enough
About What Goes on in Resident's Day Program or Placement

Yes/No	Foster		Group		ICF-MR		x^2
	1-4 (N=58)	5-6 (N=57)	1-4 (N=48)	5-6 (N=73)	1-4 (N=29)	5-6 (N=35)	
Yes	84.5%	84.2%	72.9%	65.8%	72.4%	68.6%	
No	15.5	15.8	27.1	34.2	27.6	31.4	9.68
Total	100.0	100.0	100.0	100.0	100.0	100.0	

Data gathered on day program services for persons living in small residential facilities indicated that most individuals are enrolled in some structured daytime activity for approximately five or more hours per day. There were reported to be frequent and varied contacts between residential and day program personnel. Personnel in residential facilities indicated that they considered themselves to have a good knowledge of the nature and activities of the day program placements. Nearly all of the placements were in specialized and structured day program activities, with little apparent opportunity for integration with non-disabled peers. Very few options were available to this sample for community-based training programs or supported work experiences in community settings.

Special Services

A number of questions were asked to assess the extent to which residents in the three programs received special services either inside or outside the facility. Table 5.23 presents the number of times in the past year that residents had seen medical doctors. The information in this table indicates that the vast majority of persons with mental retardation in these facilities had seen a physician less than

five times during the past year. There were no statistically significant differences among the types and sizes of residential placement and the frequency of seeing medical doctors.

In a related question, an attempt was made to assess whether persons in these residential facilities saw doctors within the facility or in some community setting (see Table 5.24). The vast majority of residents in these facilities saw a doctor in a community clinic. Smaller numbers of persons saw doctors in community hospitals and other special treatment settings. The major difference which seemed to appear among types of facilities was in the use of medical services by persons in foster home placements. The individuals in foster homes tended to use the personal doctor of the provider much more often than residents of group homes and ICFs-MR.

Table 5.23

Number of Times in the Past Year Resident Had Seen a Physician

Number of Times	Foster		Group		ICF-MR		x^2
	1-4 (N=68)	5-6 (N=66)	1-4 (N=51)	5-6 (N=71)	1-4 (N=30)	5-6 (N=34)	
None	1.5%	1.5%	0.0%	0.0%	0.0%	0.0%	
Once to twice	44.1	27.3	29.4	35.2	30.0	23.5	
Three to five times	38.2	28.8	29.4	35.2	20.0	41.2	
Six to nine times	4.4	15.2	23.5	12.7	13.3	14.7	32.04
10 to 19 times	11.8	18.2	15.7	14.1	26.7	14.7	
20 or more times	0.0	9.1	2.0	2.8	10.0	5.9	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

In most cases, health services were contracted through clinics and other health care providers. The extent of careprovider satisfaction with the quality of health care is reported in Table 5.25. The majority of respondents reported that they were very satisfied or quite satisfied with the quality of medical care received by residents in their programs. The rate of satisfaction approximated or exceeded 80% among all the groups of respondents, except those from larger ICFs-MR. They reported a somewhat lower general enthusiasm with available health care services, although not so much as to yield a statistically significant difference among facilities. When asked to elaborate on the types of

problems in medical care, most of the responses were concerned with the lack of sufficient time provided by doctors or the lack of thoroughness in the medical services.

Table 5.24

Physician Used by Residents

Where	Foster		Group		ICF-MR	
	1-4 (N=69)	5-6 (N=63)	1-4 (N=51)	5-6 (N=74)	1-4 (N=30)	5-6 (N=33)
Same community based physician that careperson uses	42.0%	42.9%	3.9%	4.1%	6.7%	21.2%
Community clinic/office	52.2	55.6	80.4	67.6	76.7	78.8
Community hospital	13.0	22.2	25.5	20.3	36.7	18.2
At a state-operated facility	0.0	0.0	3.9	4.1	0.0	3.0
At residential facility	0.0	1.6	0.0	5.4	0.0	0.0
Goes to a specialist	5.8	9.5	3.9	12.2	0.0	12.1
Other or not specified	8.7	4.8	7.8	5.4	10.0	0.0

Note. Columns do not total 100% because respondents could select more than one alternative.

Table 5.25

Respondent's Degree of Satisfaction With the Quality of Medical Care the Resident Receives

Degree of Satisfaction	Foster		Group		ICF-MR		x^2
	1-4 (N=69)	5-6 (N=67)	1-4 (N=52)	5-6 (N=77)	1-4 (N=32)	5-6 (N=34)	
Very satisfied/satisfied	88.4%	88.1%	88.5%	79.2%	87.5%	70.6%	
Some problems, but generally satisfied	7.2	10.4	9.6	18.2	12.5	23.5	11.73
Not satisfied/would change doctors if another one were available	4.3	1.5	1.9	2.6	0.0	5.9	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

Table 5.26 presents the number of times during the previous year that residents received dental services. Approximately 70% of residents in all facility types had seen dentists one or two times during the preceding year. About 15% of the residents of these facilities made more frequent use of dental services, and only 5% did not receive dental services at all during the past year.

Table 5.26

Number of Times in the Past Year Resident Had Seen a Dentist

Number of Times	Foster		Group		ICF-MR		x^2
	1-4 (N=68)	5-6 (N=66)	1-4 (N=52)	5-6 (N=76)	1-4 (N=32)	5-6 (N=34)	
None	8.8%	9.1%	0.0%	2.6%	0.0%	2.9%	
Once to twice	73.5	81.8	76.9	75.0	81.3	85.3	18.13
Three to five times	13.2	7.6	19.2	18.4	12.5	11.8	
Six or more times	4.4	1.5	3.8	3.9	6.3	0.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

Table 5.27 includes information on the proportion of residents who received other types of specialized services during a one year period. In all about 50% of the residents of the sampled facilities had received medical specialist services in one form or another in the previous year. However, residents of foster homes were less likely to use services provided by medical specialists than group home and ICF-MR residents (X^2 (5) = 15.9, $p < .01$). The extent of nursing services use by persons with mental

Table 5.27

Support Services Received by Residents During a 12 Month Period

Type of Services	Foster		Group		ICF-MR		x^2
	1-4 (N=57)	5-6 (N=52)	1-4 (N=42)	5-6 (N=63)	1-4 (N=30)	5-6 (N=33)	
Medical Specialist	40.4%	32.7%	62.5%	53.2%	70.0%	48.5%	15.89**
Nurse	14.3	27.5	23.8	32.3	86.2	81.8	76.66**
Nutritional/Dietician	1.8	5.8	17.1	18.0	57.1	42.4	54.65**
Occupational Therapist	8.9	11.5	11.9	13.1	21.4	33.3	12.15*
Physical Therapist	17.9	21.2	21.4	9.8	17.9	37.5	10.54
Speech Therapist	26.8	21.2	39.5	17.5	58.6	60.6	31.99**
Professional Counselor	1.8	0.0	22.0	14.8	10.7	12.5	18.83**
Psychologist	15.8	9.6	41.9	27.9	64.3	60.6	47.27**
Social Worker	58.9	67.3	32.5	63.5	86.2	69.7	23.70**

* $p < .05$
** $p < .01$

retardation in these residential placements was relatively limited. In the case of foster homes and group homes, approximately one-quarter of the residents received nursing services. In the case of ICFs-MR, however, there was a much greater tendency to have used nursing services (84%), with most of these facilities reporting they had nurses on staff. Other services with statistically significant patterns of use among the different facility types were occupational therapy (most in ICFs-MR), speech therapy (most in ICFs-MR), professional counseling (most in group homes), psychologists (most in ICFs-MR, least in foster homes) and social workers (most in ICFs-MR, least in group homes).

Questions were also asked about the extent to which respondents felt that the various support services received by residents were adequate (see Table 5.28). Respondents rarely felt that residents were getting too much service. Of the services received by residents that the careproviders felt needed to be increased, most commonly mentioned was speech therapy, psychological services and social work services. Foster parents were somewhat less likely than group home staff to say that residents needed more intensive service than they already received, but the difference was not statistically significant.

Table 5.29 presents information on the provider of support services. Among foster homes and group homes, very few of the specialized professional services were provided by paid staff of the residential facilities. In ICFs-MR, there was a greater tendency to rely upon personnel employed by the facility or its operating agency to provide nursing and dietary services, social work services, counseling and therapeutic services, as well as psychological services. In general staff members reported high rates of satisfaction with the support services provided. The lowest rates of satisfaction were reported for occupational therapy, speech therapy, counseling and psychological services. In general staff members reported high rates of satisfaction with the support services provided. The lowest rates of satisfaction were reported for occupational therapy, speech therapy, counseling and psychological services.

Table 5.28

Adequacy of Support Services Received by Residents

Degree of Adequacy	Foster		Group		ICF-MR		x^2
	1-4 (N=57)	5-6 (N=52)	1-4 (N=42)	5-6 (N=63)	1-4 (N=30)	5-6 (N=33)	
Medical Specialist							
Just right	36.3%	29.3%	55.0%	44.9%	70.0%	45.3%	
Need more	4.0	1.7	5.0	6.7	0.0	3.2	5.60
Need less	0.0	1.7	2.5	1.7	0.0	0.0	
Total in year	40.4	32.7	62.5	53.2	70.0	48.5	
Nurse							
Just right	14.3%	25.7%	20.6%	28.4%	69.0%	81.8%	
Need more	0.0	1.7	3.2	3.9	17.2	0.0	7.53
Need less	0.0	0.0	0.0	0.0	0.0	0.0	
Total in year	14.3	27.5	23.8	32.3	86.2	81.8	
Nutritional/Dietician							
Just right	1.8%	4.6%	12.2%	15.5%	44.4%	37.1%	
Need more	0.0	1.2	4.9	2.6	9.5	5.3	5.37
Need less	0.0	0.0	0.0	0.0	3.2	0.0	
Total in year	1.8	5.8	17.1	18.0	57.1	42.4	
Occupational Therapist							
Just right	5.4%	8.2%	8.9%	6.6%	19.0%	22.2%	
Need more	1.8	1.6	3.0	5.2	2.4	11.1	9.65
Need less	1.8	1.6	0.0	1.3	0.0	0.0	
Total in year	8.9	11.5	11.9	13.1	21.4	33.3	
Physical Therapist							
Just right	11.4%	13.5%	18.6%	7.9%	17.9%	32.8%	
Need more	6.5	7.7	2.9	1.3	0.0	4.7	11.81*
Need less	0.0	0.0	0.0	0.7	0.0	0.0	
Total in year	17.9	21.2	21.4	9.8	17.9	37.5	
Speech Therapist							
Just right	17.9%	15.5%	27.0%	10.0%	33.9%	39.4%	
Need more	7.1	5.6	12.6	7.5	24.7	18.2	6.53
Need less	1.8	0.0	0.0	0.0	0.0	3.0	
Total in year	26.8	21.2	39.5	17.5	58.6	60.6	
Professional Counselor							
Just right	0.9%	0.0%	12.5%	9.0%	10.7%	8.3%	
Need more	0.9	0.0	9.4	4.9	0.0	4.2	7.30
Need less	0.0	0.0	0.0	0.8	0.0	0.0	
Total in year	1.8	0.0	22.0	14.8	10.7	12.5	
Psychologist							
Just right	13.8%	8.5%	27.2%	21.8%	54.1%	51.9%	
Need more	0.0	1.1	14.7	4.8	10.2	5.8	11.11*
Need less	2.0	0.0	0.0	1.2	0.0	2.9	
Total in year	15.8	9.6	41.9	27.9	64.3	60.6	
Social Worker							
Just right	56.9%	65.0%	30.2%	53.4%	62.1%	63.4%	
Need more	2.0	2.3	2.3	10.1	24.1	6.3	11.47*
Need less	0.0	0.0	0.0	0.0	0.0	0.0	
Total in year	58.9	67.3	32.5	63.5	86.2	69.7	

* $p < .05$

Table 5.29

Provider of Support Services and the Respondent's Satisfaction
With the Quality of Services Received for Residents Who Receive Service

Type of Services	Foster		Group		ICF-MR	
	1-4 (N=27)	5-6 (N=31)	1-4 (N=24)	5-6 (N=38)	1-4 (N=23)	5-6 (N=25)
Medical Specialist						
Provider						
Residence staff	11.8%	5.9%	16.7%	16.1%	44.4%	0.0%
Day program staff	0.0	16.7	0.0	3.2	5.6	0.0
Other staff	88.2	82.4	83.3	80.6	63.2	100.0
Quality						
Satisfied	94.7	100.0	100.0	93.5	100.0	93.3
Not satisfied	5.3	0.0	0.0	6.5	0.0	6.7
Nurse						
Provider						
Residence staff	14.3%	42.9%	12.5%	36.8%	65.2%	63.0%
Day program staff	28.6	28.6	25.0	22.2	41.7	25.9
Other staff	62.5	42.9	62.5	50.0	17.4	25.9
Quality						
Satisfied	100.0	91.7	100.0	88.9	91.3	100.0
Not satisfied	0.0	8.3	0.0	11.1	8.7	0.0
Nutritional/Dietician						
Provider						
Residence staff	0.0%	0.0%	0.0%	27.3%	60.0%	46.2%
Day program staff	0.0	0.0	0.0	50.0	12.5	30.8
Other staff	100.0	100.0	100.0	30.0	33.3	38.5
Quality						
Satisfied	100.0	100.0	100.0	90.9	93.3	85.7
Not satisfied	0.0	0.0	0.0	9.1	6.7	14.3
Occupational Therapist						
Provider						
Residence staff	0.0%	40.0%	0.0%	0.0%	50.0%	30.0%
Day program staff	100.0	86.4	75.0	80.0	54.5	33.3
Other staff	0.0	20.0	80.0	62.5	33.3	50.0
Quality						
Satisfied	100.0	100.0	60.0	57.1	85.7	81.8
Not satisfied	0.0	0.0	40.0	42.9	14.3	18.2
Physical Therapist						
Provider						
Residence staff	0.0%	25.0%	0.0%	50.0%	33.3%	36.4%
Day program staff	60.0	44.4	22.2	33.3	50.0	27.3
Other staff	40.0	37.5	77.8	50.0	33.3	54.5
Quality						
Satisfied	100.0	70.0	100.0	100.0	100.0	100.0
Not satisfied	0.0	30.0	0.0	0.0	0.0	0.0
Speech Therapist						
Provider						
Residence staff	6.7%	10.0%	6.7%	18.2%	41.2%	10.5%
Day program staff	80.0	50.0	40.0	80.0	41.2	31.6
Other staff	13.3	40.0	53.3	10.0	17.6	57.9
Quality						
Satisfied	93.3	90.9	81.3	80.0	81.3	80.0
Not satisfied	6.7	9.1	18.8	20.0	18.8	20.0

(table continues)

Type of Services	Foster		Group		ICF-MR	
	1-4 (N=27)	5-6 (N=31)	1-4 (N=24)	5-6 (N=38)	1-4 (N=23)	5-6 (N=25)
Professional Counselor						
Provider						
Residence staff	0.0%	0.0%	25.0%	0.0%	100.0%	50.0%
Day program staff	0.0	0.0	0.0	66.7	33.3	25.0
Other staff	100.0	0.0	75.0	33.3	0.0	25.0
Quality						
Satisfied	0.0	0.0	75.0	55.6	100.0	80.0
Not satisfied	100.0	0.0	25.0	44.4	0.0	20.0
Psychologist						
Provider						
Residence staff	16.7%	40.0%	16.7%	21.4%	57.1%	15.8%
Day program staff	0.0	0.0	11.1	7.7	28.6	10.5
Other staff	83.3	60.0	72.2	76.9	33.3	73.7
Quality						
Satisfied	100.0	80.0	70.6	84.6	86.7	94.7
Not satisfied	0.0	20.0	29.4	15.4	13.3	5.3
Social Worker						
Provider						
Residence staff	7.4%	23.3%	41.7%	20.5%	68.2%	26.1%
Day program staff	11.1	13.3	8.3	13.2	43.5	30.4
Other staff	82.1	66.7	50.0	68.4	4.5	60.9
Quality						
Satisfied	100.0	100.0	100.0	84.2	90.9	95.7
Not satisfied	0.0	0.0	0.0	15.8	9.1	4.3

Note. Totals for who provided service may be greater than 100% if service was provided by more than one source.

Table 5.30 summarizes respondents' perceptions of services needed but not received by sample members. Across all facility groups, most respondents indicated that no further services were needed by their residents. Approximately 10-30% of the respondents depending upon the particular facility type indicated some need for additional outside service. Speech therapy was the specific service most frequently noted as needed, but not received, but only by 4% of the respondents. Respondents indicating that services were insufficient for their residents indicated that availability was the primary reason rather than financial reimbursement for provision of particularly needed services.

In reviewing the various tables in this section, it is reasonable to conclude that the majority of respondents considered specialized community support services to be adequately available to the residents of their facilities. Respondents reported themselves to be reasonably well satisfied with the availability, timeliness, and quality of specialized support services in their communities. While problems

exist in providing necessary support to providers of these smaller residential facilities, the pattern of responses in this study suggested that in the vast majority of cases, respondents felt reasonably well supported in their efforts to provide for the needs of persons living in community residential facilities.

Table 5.30

Services Resident Needs But Does Not Receive

Type of Services	Foster		Group		ICF-MR		x^2
	1-4 (N=65)	5-6 (N=59)	1-4 (N=47)	5-6 (N=71)	1-4 (N=29)	5-6 (N=33)	
None	89.2%	86.4%	74.5%	85.9%	89.7%	72.7%	
Medical specialist	3.1	0.0	2.1	1.4	0.0	3.0	
Nutritional/dietician	0.0	1.7	0.0	0.0	0.0	0.0	
Occupational therapist	0.0	0.0	2.1	2.8	0.0	3.0	
Physical therapist	0.0	0.0	0.0	2.8	0.0	0.0	
Speech therapist	1.5	3.4	8.5	4.2	0.0	6.1	47.36
Professional counselor	3.1	1.7	4.3	0.0	0.0	3.0	
Psychologist	0.0	0.0	2.1	0.0	0.0	0.0	
Social worker	0.0	0.0	0.0	0.0	3.4	0.0	
Other	3.1	6.8	6.4	2.8	6.9	12.1	
Total	100.0	100.0	100.0	100.0	100.0	100.0	

CHAPTER 6

INTEGRATION INTO THE LIFE OF THE COMMUNITY[1]

The goal of community integration underlies much of the change that has taken place in residential services for people with mental retardation in recent years. Still, relatively little research has examined the extent to which current placement practices favoring physical movement of individuals to normal communities actually results in their integration into the life of those communities. Even less research has attempted to identify the factors that are associated with actual integration. This chapter uses data on the activities and experiences of sample members gathered in this study, as well as additional data gathered on a comparison group of "average" Americans to examine the relative levels of integration of persons with mental retardation in community settings. This substudy sought to answer questions such as: Are residents of small foster homes, group homes, and ICFs-MR different than members of the general population in their degree of integration into the life of the community? If so, in what areas of community integration are they different and which residents of which facilities are most notably different? What non-resident variables are significantly associated with overall integration into the life of the community? What variables account for differences in integration in four basic areas of integration (domestic, vocational-educational, recreation-leisure, and social) into the life of the community?

Dependent Variables (Measures of Integration)

Operational definitions of integration were built from and, therefore, constrained by the survey questions. "Integration into the life of the community" in this study was defined as being all of the following:

1. involved to a "normal" extent in the domestic-centered routines and activities of the community (e.g., cleaning house, shopping for groceries). Thus, an individual could be isolated in his or her home setting and yet integrated into the normal domestic routines of the community. Conversely an individual could experience many recreational and other activities in the community in which he/she lived but not be integrated into the domestic routines of the community (i.e., not have a domestic lifestyle that involves routines that are standard for the individual's age and sex).

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[1]For a more detailed description of this substudy, see Copher (1988).

2. involved to a "normal" extent in the vocational and educational-centered routines and activities of the community (i.e., educated or working in a setting such as competitive employment, on-the-job-training, or regular class placement that involves equal status and contact with individuals who are not handicapped).

3. making "normal" use of community facilities and resources for the purpose of engaging in leisure or recreational activities (e.g., bowling, dancing, going out to eat, or "recreational" shopping).

4. involved to a "normal" degree in the social network of the community (e.g., giving or receiving support, advice, or assistance).

These four subdivisions each focused on a different *purpose for behavior*--i.e., whether the goals of behavior were primarily domestic, vocational and educational, recreational or leisure, or social.

To determine professional and general agreement regarding the operational definitions, the above definitions along with explanatory comments, and lists of survey variables were first presented to five professors (special education, educational psychology, and community psychology), revised in accordance with suggested changes, and then presented to six special education doctoral students and four lay individuals to assess agreement on the proposed selection and categorization of survey items into the four components (domestic, vocational or educational, recreation or leisure, social). The first process required two presentations of the definitions before agreement was reached. The second resulted in 100% agreement with the proposed categorizations for 11 items, 90% agreement for 11 items, and 80% agreement for a single item, which ended up being deleted in the item analysis below.

An item analysis was also undertaken to select items that clustered for the components with more than two items representing them (domestic and recreation-leisure integration). The final domestic integration scale of 10 items (1 original item was deleted) had an alpha coefficient of .90 and a cross validation alpha of .89. The final recreation-leisure integration scale of 6 items (3 original items were deleted) had an alpha coefficient of .72 with a cross-validation alpha of .71. Table 6.1 shows the items selected to represent these definitions. Correlations among the items of all four components showed that correlations within components were generally higher than correlations among components, suggesting that the four components measured different constructs.

Table 6.1
Definitions and Items for the Dependent Variables:
The Components of "Integration into the Life of the Community"

Component	Items (paraphrased)	Coding
1. Domestic Integration	Does the subject regularly do or help with the following? a. laundry b. taking out the trash c. vacuuming, housecleaning d. mowing the lawn e. making or changing a bed f. food preparation or setting a table g. doing the dishes h. buying groceries i. cleaning own room j. cleaning rest of house	Yes responses to items a-j were summed.
2. Vocational Integration	Which (one) of the following does the subject regularly engage in?: a. on-the-job-training b. competitive employment c. regular classes in a regular school d. regular & special classes in a regular school e. staying home f. day activity center g. work activity placement h. sheltered workshop i. special class in a regular school j. special class in a special school	Items a-d coded as integrated; items e-j coded as non-integrated
3. Leisure Integration	Does the subject regularly (usually every week) perform or engage in the following?: a. going to the movies b. shopping c. swimming d. bowling or other sports e. going to the park f. going to a sporting event	Items a-f summed.
4. Social Integration	Does the subject either: a. have anyone special to to whom he/she goes for advice or guidance? b. have anyone who depends on him/her for advice, support, or assistance?	Code as yes (integrated) or no (non-integrated)

Independent Variables (Predictors of Integration)

Based on a literature review and constrained by the data at hand, the following variables were selected as possible predictors of integration into the life of the community for people with mental retardation in residential facilities.

- age
- sex
- level of retardation (rated on a scale from 5-profound to 1-borderline)
- adaptive behavior score (based on a summation of the behaviors from a list of 11 that the subject performed independently)
- problem behavior score (based on a summation of the ratings for a list of eight behaviors rated on a scale from 0- not serious- to 4- extremely serious)
- number of family contacts
- training of the care provider (survey respondent)
- experience of the care provider (survey respondent)
- programming in the residence (presence versus absence of programming for either self-care skills or community living)
- staff turnover in the residence (rating of little-none versus high-medium)
- facility type (family care home, group home, or ICF-MR)
- facility size (number of residents)
- case manager contact (number of visits to residence)
- type of community (urban,rural,etc.)
- type of neighborhood (homes, homes and apartments, etc.)
- distance of the residence to a bus stop and to stores other than the grocery store
- presence of "volunteers" who come for social activity or to take the subject out

Comparison Group of Average Americans

For the random sample of the general population, a listing of United States telephone area codes and prefixes was obtained (AT&T, 1985). Area code-prefix combinations were selected randomly from this list, and the four final digits for the phone numbers were selected from a random number table. Actual subjects for this survey were selected randomly from households upon placement of the phone calls. Calls were made from August 3rd to September 19th, 1987 when 100 questionnaires were completed. Phone numbers were tried at least three times on three different days, including one

weeknight and one weekend, or until an operator or some other person answered. People who were too busy to complete the questionnaire at the time of the call but willing to complete one at a later time were accommodated. The person who answered the phone was asked whether an adult (18 or older) in the household was willing to complete the survey (serve as a respondent). If this was so, the respondent was then asked to list all household members' names or initials. Based on the order of listing, a number was assigned each person (first=1, second=2, third=3, etc.). A random number table was used to determine which household member would be the subject of the survey.

Of 298 households reached among 1,330 phone numbers dialed, 100 (33%) agreed to complete the survey. Those completing the questionnaires were from 35 different states. There were two or three completed questionnaires in most of these states. Six states had five or more individuals who completed questionnaires: California (8), Illinois (8), Florida (7), Texas (7), Maryland (6), and New York (5).

Analyses

Four sets of analyses were undertaken. First, chi-square analyses and a t-test were done to check for differences between the residential facility samples and the sample of persons from the general population on independent variables (other than residential living arrangement and intelligence level). Second, multivariate analysis of variance and discriminant analysis were used to determine if there were significant differences among groups in regard to dependent variables (integration into the life of the community). Third, a canonical correlation was used to determine which independent variables were most highly associated with integration into the life of the community. Finally, multiple regression analyses were used to determine the variance in each of the components of integration into the life of the community -- (a) domestic integration, (b) vocational-educational integration, (c) recreation-leisure integration, and (d) social integration -- accounted for by the independent variables.

Group Differences on independent variables. Table 6.2 compares the general population sample with the residential facility samples combined on variables that might predict integration into the life of the community. A t-test showed no significant difference between the two groups in age.

Similarly, chi-square analyses found no significant differences in gender, community type, or proximity to a bus stop. The only significant differences found to exist between the two groups were neighborhood type and distance from stores. The residential facility sample more often than the general population resided in areas with mixed homes and apartments or mixed homes and businesses, but less often resided in areas with primarily family homes, X^2 (4,N=428)=15.13, $p < .05$. The residential facility sample was also more often within 10 blocks of stores than was the general population sample, X^2 (1,N=426)=17.75, $p < .05$).

Table 6.2
Comparison of General Population and Residential Facility Samples
on Variables That Might Affect Integration

Variable	General Population Sample	Residential Facility Sample
Age: (mean(s.d.))	35.70(20.30)	33.22(16.13)
Sex: (percent male)	50.9%	54.0%
Proximity to bus stop (closer than 1 mile)	55.0%	64.3%
Proximity to stores (closer than 1 mile)	48.0%	71.5%*
Community type		
rural	27.0%	21.3%
small town	9.0	11.9
large town	19.0	24.6
city	18.0	15.5
suburb	27.0	26.7
Neighborhood type		
primarily family homes	82.8%	71.1%*
mixed homes and apts	8.1	13.7
primarily businesses	1.0	0.0
mixed business and residential	4.0	13.7
other	4.0	1.5

* $p < .05$

Group differences on dependent variables (integration). Comparison of integration into the life of the community among the four groups using a multivariate analyses of variance indicated that there was a significant difference among the four groups, $F(12,915.72)=47.63$, $p < .001$. The first of three significant discriminant functions reflected better vocational(and educational)-social integration on

the part of members of the general population than on the part of all three groups of people in residential facilities. The second discriminant function, comprised mostly of domestic, but also of recreation-leisure items, showed poorer domestic and somewhat poorer recreation- leisure integration on the part of family care residents compared to the other three groups and high domestic and relatively high recreation-leisure integration on the part of group home residents. (The general population received high domestic integration ratings, but relatively low recreation- leisure integration ratings, while ICF-MR residents received high leisure but relatively low domestic integration ratings.) The third discriminant function could be labeled "good recreation(and leisure)-social integration," with a heavier weighting on good leisure than good social integration. This significant discriminant function reflected ICF-MR residents' higher ratings on recreation-leisure integration than the other three groups and slightly higher ratings on social integration than the family care and group home residents. Each group's raw scores on the four separate integration variables are shown in Table 6.3.

Table 6.3
Comparison of the General Population, Foster Home, Group Home, and ICF-MR Samples on the Four Components of "Integration into the Life of the Community"

Integration component	Group				F for one-way ANOVA for each component
	general population M (s.d)	family care M (s.d.)	group home M (s.d.)	ICF-MR M (s.d.)	
Domestic	.81(.31)	.44(.33)	.79(.32)	.67(.35)	30.93* (N=424)
Vocational-educational	.78(.42)	.05(.21)	.05(.22)	.02(.13)	190.56* (N=416)
Recreation-leisure	.62(.27)	.64(.32)	.77(.27)	.85(.19)	13.09* (N=404)
Social	.82(.39)	.20(.40)	.21(.41)	.24(.43)	42.25* (N=395)

*p < .0001

Predictors of Community Integration

Overall. Examination of factors associated with overall "integration into the life of the community" using a canonical correlation analysis and Rao's F-approximation to test the obtained Wilks' lambda revealed two significant canonical correlations. The first canonical correlation between the first canonical

variate of overall integration and the first canonical variate of the independent variables was found to be .70, $F(144,934.64)=2.40$, $p < .001$; the second canonical correlation between the second canonical variate of overall integration and the second canonical variate of the independent variables was found to be .52, $F(105,951.90)=1.38$, $p = .01$. In other words, 50% of the variance was shared by the first pair of canonical variates and 27% of the variance in the residuals from the first pair of canonical variates was shared by the second pair of canonical variates. The first canonical correlation primarily represented an association between high scores on domestic-recreation(and leisure) integration (with heaviest weighting on domestic integration) with group home placement, greater adaptive behavior, less severe retardation, and neighborhoods comprised of mixed homes and apartments. The second canonical correlation primarily represented an association between low scores on recreation(and leisure)-vocational integration (with heavier weighting on leisure integration) and less frequent case management, family care placement, and increased resident age.

In completing several regression analyses, independent variables were entered in four steps:

1. Resident characteristics: age, sex, level of retardation, adaptive behavior score, and maladaptive behavior score

2. Characteristics of the small group setting: care provider training and experience, formal habilitation training programs within the residential facility, staff turnover within the residential facility, and resident's contact with family

3. Characteristics of the residential facility organization: facility size and type

4. Community characteristics: neighborhood type, community type, proximity to community facilities, benefactor presence, and case management

In this way, smaller scale variables (i.e., those characterizing smaller units, which were entered earlier) were cumulatively controlled (held constant) in examination of larger scale variables (which were entered later).

Domestic integration. Results of the regression analysis that was used to examine factors specifically associated with domestic integration are presented in Table 6.4. Independent variables accounting for at least six percent of the variance in scores (R-square change) included severity of

Table 6.4

Regression Analysis Summary Table for the Association Between Domestic Integration and the Selected Independent Variables (N=324)

	R^2 Change	Simple Correlation
STEP A. INDIVIDUAL LEVEL VARIABLES		
1. Age	.012*	.12
2. Sex	.013*	-.15
3. Level of retardation	.057*	-.32
Level of retardation missing		.23
4. Adaptive behavior	.056*	.40
Adaptive behavior missing		.00
5. Maladaptive behavior	.009*	-.00
STEP B. SMALL GROUP LEVEL VARIABLES		
6. Care provider training	.007	.12
Care provider training missing		.00
7. Care provider experience	.058*	-.24
Care provider experience missing		-.12
8. Staff turnover	.013*	.13
Staff turnover missing		.14
9. Programming	.010*	.11
Programming missing		-.04
10. Family contact	.010*	.10
Family contact missing		-.05
STEP C. ORGANIZATIONAL LEVEL VARIABLES		
11. Facility type	.081*	
Family care		-.44
Group home		.38
ICF-MR		.08
12. Facility size	.006	-.11
Facility size missing		.05
STEP D. COMMUNITY LEVEL VARIABLES		
13. Neighborhood type	.014*	
Primarily family homes		-.00
Mixed homes and apartments		.14
Mixed business and residential		-.14
14. Community type	.008*	
City		.02
Suburb		.03
Large town		.01
Small town		.01
Rural		-.09
15. Proximity to community facilities	.000	-.07
Proximity missing		.06
16. Presence of benefactor	.012*	.03
Presence of benefactor missing		.10
17. Case management	.016*	-.14
Case management		-.05
TOTAL	.38	.62

*.05 R^2 CHANGE > .008

retardation, adaptive behavior, care provider experience, and facility type. Based on the simple correlations, less severe retardation, greater adaptive behavior, less care provider experience, and group home residence were associated with greater domestic integration. Other independent variables

that accounted for a significant proportion of the variance in domestic integration scores included age, sex, family contact, programming, staff turnover, benefactor presence, community type, neighborhood type, and case management. Based on the simple correlations, older age, being male, more family contact, habilitation programs in the facility, greater staff turnover, benefactor presence, nonrural residence, mixed home-and-apartment neighborhoods, and less frequent case manager visits were associated with greater domestic integration.

Vocational-educational integration. Results of the regression analysis that was used to examine factors specifically associated with vocational-educational integration are presented in Table 6.5. Independent variables that accounted for a significant proportion of the variance in recreation-leisure integration scores included frequency of case management and staff turnover. Based on the simple correlations, more frequent visits by a case manager and less staff turnover were associated with less vocational-educational integration.

Recreation-leisure integration. Results of the regression analysis that was used to examine factors specifically associated with recreation-leisure integration are presented in Table 6.6. Independent variables that accounted for a significant proportion of the variance in recreation-leisure integration scores included adaptive behavior, habilitation programs in the facility, facility type, neighborhood type, case management, and care provider experience. Based on the simple correlations, adaptive behavior, programming, ICF-MR residence, neighborhoods of mixed business and residences, increased case manager contact, and less care provider experience were associated with higher ratings on recreation-leisure integration.

Social integration. Results of the regression analysis that was used to examine factors specifically associated with social integration are presented in Table 6.7. Independent variables that accounted for a significant proportion of the variance in social integration scores included family contact, frequency of case management contacts, severity of retardation, and adaptive behavior. Based on the simple correlations, increased family contact, less frequent case manager visits, less severe retardation, and greater adaptive behavior were associated with greater social integration.

Table 6.5

Regression Analysis Summary Table for the Association Between Vocational-Educational Integration and the Selected Independent Variables

	R^2 Change	Simple Correlation
STEP A. INDIVIDUAL LEVEL VARIABLES		
1. Age	.002	.08
2. Sex	.001	.04
3. Level of retardation	.001	.02
Level of retardation missing		-.02
4. Adaptive behavior	.008	.02
Adaptive behavior missing		.08
5. Maladaptive behavior	.002	.05
STEP B. SMALL GROUP LEVEL VARIABLES		
6. Care provider training	.002	.01
Care provider training missing		-.03
7. Care provider experience	.001	.05
Care provider experience missing		-.04
8. Staff turnover	.014*	-.06
Staff turnover missing		.11
9. Programming	.003	-.10
Programming missing		-.03
10. Family contact	.001	-.04
Family contact missing		-.02
STEP C. ORGANIZATIONAL LEVEL VARIABLES		
11. Facility type	.004	
Family care		.06
Group home		-.05
ICF-MR		-.01
12. Facility size	.000	-.03
Facility size missing		-.02
STEP D. COMMUNITY LEVEL VARIABLES		
13. Neighborhood type	.003	
Primarily family homes		.03
Mixed homes and apartments		.03
Mixed business and residential		-.06
14. Community type	.008	
City		-.02
Suburb		.09
Large town		-.09
Small town		.05
Rural		.00
15. Proximity to community facilities	.009	.02
Proximity missing		-.03
16. Presence of benefactor	.002	.03
Presence of benefactor missing		-.03
17. Case management	.013*	.03
Case management missing		-.04
TOTAL	.08	.28

*.05 R^2 CHANGE > .012

Table 6.6

Regression Analysis Summary Table for the Association Between Recreation-Leisure Integration and the Selected Independent Variables

	R^2 Change	Simple Correlation
STEP A. INDIVIDUAL LEVEL VARIABLES		
1. Age	.006	-.04
2. Sex	.003	-.03
3. Level of retardation	.003	-.08
Level of retardation missing		-.03
4. Adaptive behavior	.067*	.24
Adaptive behavior missing		-.00
5. Maladaptive behavior	.000	-.05
STEP B. SMALL GROUP LEVEL VARIABLES		
6. Care provider training	.003	.03
Care provider training missing		.02
7. Care provider experience	.021*	-.08
Care provider experience missing		-.05
8. Staff turnover	.010	.04
Staff turnover missing		.08
9. Programming	.041*	.17
Programming missing		.06
10. Family contact	.003	.04
Family contact missing		-.05
STEP C. ORGANIZATIONAL LEVEL VARIABLES		
11. Facility type	.036*	
Family care		-.19
Group home		-.01
ICF-MR		.24
12. Facility size	.002	.03
Facility size missing		.03
STEP D. COMMUNITY LEVEL VARIABLES		
13. Neighborhood type	.030*	
Primarily family homes		-.11
Mixed homes and apartments		-.10
Mixed business and residential		.05
14. Community type	.009	
City		.04
Suburb		.00
Large town		.02
Small town		-.04
Rural		-.02
15. Proximity to community facilities	.006	-.02
Proximity missing		-.11
16. Presence of benefactor	.002	-.03
Presence of benefactor missing		-.00
17. Case management	.017*	.10
Case management missing		.10
TOTAL	.26	.51

*.05 R^2 CHANGE > .012

Table 6.7

Regression Analysis Summary Table for the Association Between Social Integration and the Selected Independent Variables

	R^2 Change	Simple Correlation
STEP A. INDIVIDUAL LEVEL VARIABLES		
1. Age	.006	.05
2. Sex	.000	-.06
3. Level of retardation	.019*	-.18
Level of retardation missing		-.07
4. Adaptive behavior	.012*	.15
Adaptive behavior missing		.04
5. Maladaptive behavior	.004	.03
STEP B. SMALL GROUP LEVEL VARIABLES		
6. Care provider training	.004	-.01
Care provider training missing		.02
7. Care provider experience	.003	-.10
Care provider experience missing		-.05
8. Staff turnover	.000	-.01
Staff turnover missing		-.01
9. Programming	.003	.03
Programming missing		-.06
10. Family contact	.041*	.26
Family contact missing		-.04
STEP C. ORGANIZATIONAL LEVEL VARIABLES		
11. Facility type	.000	
Family care		-.02
Group home		.09
ICF-MR		-.08
12. Facility size	.001	.02
Facility size missing		.01
STEP D. COMMUNITY LEVEL VARIABLES		
13. Neighborhood type	.009	
Primarily family homes		-.05
Mixed homes and apartments		.06
Mixed business and residential		-.02
14. Community type	.002	
City		.05
Suburb		-.05
Large town		.12
Small town		-.04
Rural		-.10
15. Proximity to community facilities	.007	.02
Proximity missing		-.02
16. Presence of benefactor	.001	-.00
Presence of benefactor missing		-.02
17. Case management	.022*	-.00
Case management missing		.04
TOTAL	.14	.37

*.05 R^2 CHANGE > .012

Summary

The results of these analyses indicated that people in small residential facilities were generally not as well integrated into the life of the community as were members of the general population. The

absence of differences in age, sex, community type, and proximity to a bus stop as well as the closer proximity of residential facilities to stores (and probably other leisure sites) support attribution of these differences to living arrangement, to differences in adaptive behavior and intelligence, and/or to interaction between these factors.

The differences between people in residential facilities and the general population in integration into the life of the community was particularly evident for vocational-educational and social integration. These might be considered the more intellectually-demanding components of integration as measured in this study, but they are also the ones in which "integration" is most dependent on acceptance of community facility residents with mental retardation by nonhandicapped members of the community. In these areas, all three groups with handicaps lagged far behind the general population. In addition, on domestic-recreation(and leisure) integration, which might be labeled the more activity-oriented components of integration as measured in this study, foster home residents scored lower than the general population. As a whole, the group comparisons suggest that, if integration is to continue to be a goal of the community residential experience intervention will be required at the societal level (increasing acceptance of the worth and potential of people with mental retardation), at the facility level (increasing expectations for and commitment to providing integrated activities), and at the individual level (increasing skills to participate in and benefit from integrated activities).

To summarize briefly, this investigation indicates that, although some small facility residents are reasonably well integrated in some respects (e.g., the average group home resident has about as much domestic responsibility as measured in this study as the average member of the general population), there is generally a large gap between small facility residents and the general population in regard to the extent of integration into the daily life of the community. This gap grows wider as residents' cognitive and behavioral impairments become more severe. Because so little research has been done in this area, replication and refinement of this general type of study is needed. But uncovering ways of identifying and promoting factors associated with integration through policy, training, public awareness and other appropriate means is obviously most critical to efforts to remediate the

situation identified in this study. Research and demonstration in these areas should contribute to the effort of bringing this society closer to its goal of integration by making subgroups of small facility residents more a part of the life of the communities in which they live.

CHAPTER 7

SUMMARY AND CONCLUSIONS

This report has described the results of a study of "household scale" residential placements for persons with mental retardation (i.e., "facilities" with 6 people or less). Households of this size are occupied by about 93% of the civilian, noninstitutionalized, population of the U.S. National statistics show residential placements of this size to be the most rapidly growing out-of-home options for persons with mental retardation. Increased use of these small, household scale settings reflect greatly expanded efforts to return and/or maintain people with mental retardation in "the community." On June 30, 1988, states reported approximately 90,000 persons with mental retardation in placements with 6 or fewer other persons with mental retardation. This compares with about 33,000 on June 30, 1982 and just over 20,000 on June 30, 1977 (Lakin, Hill, & Bruininks, 1985; White, Lakin, & Bruininks, in preparation)..

Enormous strides have been made in the past several years to assure increased opportunities for persons with mental retardation to experience a physical presence in the communities of the United States. The present study indicates that in many superficial, but still significant ways the physical integration of persons with mental retardation through the expansion of community housing is progressing in desirable ways. For example over 80% of the community living arrangements sampled in this study are single family homes. Over two-thirds of these homes are located in neighborhoods primarily made up of other single family homes. The homes in multiple family units were usually in neighborhoods of mixed residential and business areas or mixed single and multiple-family settings and these, as would be expected, were usually found in urban areas. Equally important, this study has shown that opportunities for living in community based, household scale settings are being increasingly afforded to persons with all levels of mental retardation and all types of related conditions. For example, this study yielded estimates of about 12,000 persons with profound mental retardation in facilities of 6 or fewer residents nationwide at the beginning of 1987. This compares with about 4,000 in 1982. In addition nearly 10% of the residents of the facilities in this study were reported to have

medical problems requiring at least monthly visits to a physician. Therefore, while residents of these small community facilities were *on the average* less severely impaired than residents of larger public and private facilities (Lakin, Hill, & Chen, 1989), this study found many persons with severe developmental, behavioral and health problems getting along quite well, demonstrating the feasibility of community-based housing for individuals with all types and degrees of disability.

But opportunities to live in relatively typical homes in relatively typical neighborhoods are only the beginning of community life. Physical presence in community housing is obviously a necessary condition to community life, but for most persons life in a community implies other broader and more interpersonal aspects of daily life, relating to the relationships, interdependencies, and expectations that come to define communities. It is clearly the case that providing persons with mental retardation with opportunities for community living in a broader sense is considerably more challenging than merely finding community housing. It is also clearly the case, based on data gathered in this study, that individual facilities and even general types of facilities vary considerably in their success in responding to this challenge.

It may be argued that the challenge of providing high quality community living experiences to people with mental retardation involves at least 5 basic aspects beyond providing mere physical proximity to others in the community. These aspects include: 1) protecting of *basic health and safety*, including provisions for the basic ingredients of good health (appropriate medical and dental care, proper exercise), physical safety, and monitoring of well-being; 2) providing for *personal growth and development*, including experiences and direct teaching related to learning new skills and concepts that enhance personal competence and to developing and fulfilling personal interests; 3) developing, maintaining and expanding *social relationships*, including casual interactions with other people, participation in activities with other people, and ongoing relationships with friends and family; 4) providing opportunities and expectations for *valued community participation*, through valued roles within the community such as worker, consumer and neighbor, and in turn providing the respect that derives from fulfilling such roles; and 5) assuring appropriate opportunities for *personal autonomy* that permit

development and expression of independence and individuality within the standards of the community. This study attempted to gather information on these more complex and arguably more important aspects of community living for persons with mental retardation in community-based housing arrangements. Some of these findings and their implications include those summarized below.

Health and Safety

The ability of community facilities to provide for the basic health and safety of their residents is one of the most frequently noted concerns of parents whose offspring are being considered for community placements (Conroy, 1985). Obviously a survey cannot determine the quality of health services provided to persons in community settings; however, it was noted that the persons with mental retardation in the facilities studied had considerable monitoring of their basic health. Of 320 total sample members whose medical care usage was reported, only 2 (or 0.6%) had not seen a physician within the previous 12 months. Over two-thirds of all sample members had seen a physician at least 3 times in the past year. Satisfaction of care providers with the medical services available to these residents was overwhelmingly positive, with about 85% indicating satisfaction and no notable problems in the services received. All but 3% of the remainder reported general satisfaction despite some problems in medical services. Similarly dental care was available to and used by all but 5% of residents within the previous 12 months. Other health specialists were used less frequently, but respondents seldom (less than 10%) indicated that specialized health services were needed. With the exception of occupational therapy, careproviders reported general satisfaction with the quality of specialized health related services.

Case managers have a primary responsibility in assuring health and safety of residents of community living arrangements. About 93% of residents in this sample were reported to currently have case managers, with 95% of residents reported to be visited at least twice a year by their case managers. A majority reported monthly or more frequent contact with case managers. About 68% of careproviders indicated they felt the case manager understood their residents' needs, abilities and problems "very well," as compared with just 4% indicating these were understood "not at all." In general

case managers were reported to seek information about a wide range of needs of both residents and their careproviders. But frequently careproviders found case managers to be nonresponsive to the careproviders' needs for specific assistance, support and training, and uninvolved in the development and monitoring of individualized training activities.

Personal Growth and Development

An important role of community living experiences is to enhance the personal growth and development of residents. Community living should and generally does enhance the development of community living skills of residents. Skills are enhanced through direct teaching within residential, vocational and day program and through participation in the activities and routines of community living. With respect to the latter, the community facility residents in this sample were quite active in community-based activities, despite the fact that over 80% of residents were reported to require accompaniment or supervision for activities outside the residence. In fact, the participation in recreation-leisure activities of the sample of persons with mental retardation in community settings was actually higher than among the comparative sample of non-handicapped community members. Particularly interesting in this area, was the positive association between living in a mixed residential/business area and recreation and leisure activity participation. In short it was noted that people in neighborhoods where there is more to do tend to do more.

While planned activities in the community were quite evident among members of the sample, the highest rate of leisure-recreation activities were generally passive, as opposed to active activities (see Table 4.26). These activities included watching television (89%), taking rides (54%) and attending religious services (61%) at least on a weekly basis. These rates compare quite closely with those for persons without disabilities. Approximately 50% of sample members engaged in regular walking of physical exercise. These patterns of activity do indicate participation in community environments, but obviously a strong case can and should be made for greater focus on less passive leisure activities for persons who live in community-based residential facilities (just as the case is frequently made for members of the society as a whole).

While recreation and leisure participation compared favorably to the general population, participation in those domestic activities essential to maintaining a home in the community did not. Domestic participation was generally lower, among persons in residential facilities than among the sample from the general population; it was particularly low among residents of foster care homes. Formal out-of-home day programs of vocational or developmental habilitation or gainful employment were participated in by 95% of sample members. For over 95% of residents these programs and jobs involved five or more hours per day; over 95% of residents participated 5 or more days per week.

In addition to activities providing for personal growth and development, persons with mental retardation in community living arrangements require careproviders who are qualified, committed and stable enough to foster that development on an ongoing basis. Careproviders in foster care homes were distinctly different than those in the group homes and small ICFs-MR. Careproviders in small group homes and ICFs-MR tended to be young (over 75% are 36 years or younger), female, and to have had post-secondary education. Foster care providers on the other hand tended to be older (over two-thirds are 47 years or older, primarily couples who had not gone beyond high school). Despite these general differences the care providers interviewed were similar in that about half tended to have prior experiences with persons with mental retardation before taking the job, and that they tended to see satisfaction for caregiving and/or teaching as the primary reason for being a direct careprovider.

Training for careproviders in areas of importance to their function was neither universal nor consistent across settings. Foster parents reported considerably lower frequency of required pre-service training (about 54%), perhaps related to the fact that they had on average accepted their role about 13 years before the survey as compared with about 5 years for respondents from other types of facilities. Fewer foster care providers than group home staff reported having received inservice training in the past year, although foster care parents who did receive training reported more training than did careproviders in the small group homes and ICFs-MR. Overall foster care providers averaged about 15-18 hours of training in the previous year, while care providers in other facility types averaged 28-35 hours during the year, although again variability in training required and received was notable.

In general, careproviders receiving training were positive to ambivalent about its usefulness. About 70% of all respondents indicated that "most" of the training they received was useful. Interestingly, when asked in an open-ended format what, if anything, would help them be better careproviders, the staff of group homes and ICFs-MR most often mentioned some form of training, but none of the foster care respondents did, even though foster care providers averaged considerably less training. While more consistent training appears needed for all direct care staff, including both pre-service and in-service training, there seems particular need to focus on the role of training in foster care settings. Foster care providers received relatively little training and obviously had lower regard for its benefits, yet there were indicators of need. They were considerably less likely to involve their foster family members in domestic activities than were staffed facilities; foster family respondents were much less likely to see "promoting independence and dignity" as one of the most important aspects of their roles. While there is obviously much for which foster care arrangements can be commended, it also seems important to assure appropriate orientation and skills for fostering personal growth and development on the part of these providers. On the other hand, there is obviously a delicate balance between what might be desired and what may be expected given the small payments for foster care.

Inadequate consistency in staff training in community based living arrangements is exacerbated by what was considered medium to high staff turnover in about half of the staffed facilities. A majority of these and other facilities noted problems in hiring replacement staff. Over a third of all facility respondents noted one or more of the following as associated with this difficulty: finding qualified staff, finding reliable staff, finding staff willing to work for available wages, finding staff willing and able to work the hours needed. Of course, such problems are ultimately strongly affected by the funding available to facilities which are for the most part translated into wages for careproviders.

The recruitment, training and retention of personnel is obviously a critical problem in community-based residential programs. The extent of preservice and inservice training reported in this study seems inadequate in relationship to the challenges of providing appropriate opportunities for personal growth, development and community participation. For example, the restrictions on

admissions and decisions regarding demissions in these programs often cited difficulties in managing challenging behaviors of persons with mental retardation. Expanding opportunities for community living will apparently require greater attention to providing needed training for care personnel, training that leads to higher skills, and as well as associated advancement in compensation and responsibility.

Related to challenges in training is the recruitment of personnel. This problem will become increasingly acute in the recruitment of family care providers. The age profile reported in this study for foster care providers indicates that nearly 50% will reach age 65 or older in the next decade. This recruitment problem will be exacerbated by the decreasing number of households with adult members not in the work force as well as the anticipated declining numbers of available service workers after the year 2000 (Grano, 1989). Increasing the attractiveness of providing foster care through higher reimbursement rates, supplemental tax incentives, housing subsidies or other means will be needed if states hope to contain the costs of residential services and even maintain the present number of foster care providers, much less expand access to this relatively well integrated and inexpensive model of care.

Social Relationships

In recent years there has been increased attention to the importance of social relationships to persons with developmental disabilities (O'Brien, 1987; Taylor, Biklin, & Knoll, 1987). Findings from both qualitative and quantitative research have documented that community housing by no means guarantees the establishment and maintenance of social and interpersonal relationships with other members of the community. In fact social isolation has been a common theme in research on persons living in community settings. This study documented the same basic patterns on a broader base. For example, this study found that 60% of people living in community facilities had no person in their life that the careprovider would characterize as a "friend," defined as someone other than a relative or staff with whom the individual enjoyed spending time. A minority of residents were indicated to have more than one friend. Furthermore, it seemed that many careproviders lacked understanding and appreciation of the importance of social relationships in the lives of persons with developmental

disabilities. For example, not only did careproviders report that about 40% of residents had no friends, they reported that over half these individuals were "satisfied" to have no friends.

This study confirmed early findings (Birenbaum & Seiffer, 1976; Malin, 1982; Willer & Intagliata, 1984) that the most common primary friendships for persons in community residential settings are other persons with developmental disabilities, in almost three-fourth of cases a peer in their residence or day program. Facility staff or members of the foster family were reported to make up the bulk of the primary friendships of the remaining residents. Of course, it should be no surprise that persons with mental retardation draw their friendships out of their residential and work environments; this is true for many, if not most, persons without handicaps as well. Although it was found that persons with mental retardation in community residences have a much more limited social life than persons in the nonhandicapped community member sample, and that as the individual's cognitive abilities (i.e., IQ) and adaptive behavior skills decrease so do the number of social relationships, community living did contribute to the social relationships of sample members.

A substantial majority of community residents have met one or more of their neighbors. About 30% of the sample had been invited to a neighbor's home, although only 13% had visited a neighbor's home unaccompanied by staff/foster family members. Most neighbors were reported to receive residents in neutral or friendly manner, but much is left to be accomplished in facilitating and sustaining relationships between facility residents and other members of the neighborhood and broader community. It may have been once assumed that acceptance and social integration would naturally evolve from living in small community settings, but given the reported levels of social integration of people who on the average have lived in their current home for an average of 6 years, this expectation was simply not supported by this research. Clearly, social integration needs to be addressed more proactively through staff training, public awareness activities, promotion of volunteer relationships, maintaining preexisting social networks, and other demonstrably or potentially effective efforts.

Of course, families represent the single most important social relationships in most peoples' lives. Among residents with known family, less than 20% have no visits with them. On the other hand

only about 20% of the sample is reported to go to a relative's home monthly or more often and less than 15% are reported to be visited at their residence once per month or more often. Distance was not a primary impediment; over two-thirds of residents had the closest family member within two hours drive. Receptivity on the part of residents is not a factor, about half of all residents would in the judgment of care providers enjoy more contact. For about one third of all residents staff felt more should be done to involve families more actively in the lives of the member with mental retardation. Increased communication and making it easier to visit were the most frequently mentioned ways of increasing involvement. Foster family residents were considerably less frequently visited by family members, but were perceived much less frequently to want more contact. It is likely that the special situation of foster care with the resident living in someone else's home for a long period of time may complicate perceptions of the importance of the natural family in both its traditional social and advocacy roles.

Valued Community Participation

Being part of a community means participating in the community, contributing to the community, and benefitting from the resources and social institutions of the community. Much of the impetus for community living has been an assumption that it leads naturally to increased participation in culturally typical activities and relationships and increased use of community resources and services. These experiences in turn permit more normal patterns of development and more normal concepts of the culture. Equally important is the assumption that living in culturally typical housing, engaging in the productive activities associated with one's age, participating in typical leisure, social, cultural, economic and related roles, and having friends and associates who are recognized members of the community, increases the status and acceptance of persons with developmental disabilities.

Considerable research has shown the community participation of persons living in small residential settings to be much higher than persons living in institutional settings (Conroy & Bradley, 1985; Hill & Bruininks, 1981; Horner, Stoner, & Ferguson, 1988; O'Neil et al, 1981). This research also found much higher rates of community involvement of sample numbers than has been shown in studies

of institutional populations (Hill & Bruininks, 1981; Horner, Stoner, & Ferguson, 1988). Within the sample factors associated with higher relative rates of community participation included higher adaptive behavior scores, higher IQs, living in facilities other than foster homes, having careproviders who perceive promoting independence and respect as a key part of their role, living in facilities in mixed residential/business areas, and having greater amounts of contact with case managers.

Of course, the opportunities for participation provided by one's community are just one factor influencing the actual amount of engagement. It is also the case that different people given equal opportunities for participation will choose different rates and types of participation, and will often voluntarily change their participation over time (Birenbaum & Re, 1979). For these reasons, it is important that research on community living move beyond static descriptive studies such as this one, to include qualitative and/or longitudinal studies that begin to document the evolution of citizenship and community involvement of persons with developmental disabilities over time in the community.

In addition to valued participation in the community, involvement in maintaining one's own domestic environment is an important aspect of citizenship for persons with developmental disabilities. In this area, too, it is well documented that the levels of involvement of people in community settings is well above those in institutional settings (Anderson, Lakin, Bruininks, & Hill, 1987; Horner, Stoner, & Ferguson, 1988). In this study the majority of community residents were found to be engaged in a range of domestic tasks. However, domestic involvement varied substantially from facility-to-facility and was clearly associated with three broad factors: 1) severity of handicap of residents, 2) attitudes and length of service of careproviders (i.e., the longer the employment of staff, the less the involvement of residents); and 3) type of facility (i.e., foster homes provided much less involvement in domestic tasks). These findings suggest that "efficiencies" that might be characterized by "it's easier to do it myself" can come to prevail over time in residential settings, and that they are particularly likely to happen where residents need more training and support to participate in domestic tasks, and/or where the home is less likely to be seen as habilitative in purpose in addition to being a home. Clearly, increased expectations and staff training are needed to encourage and develop domestic skills use among

community residents, especially those with more severe limitations. Minimally this should include ensuring that 1) new careproviders enter their jobs with training that emphasizes the importance and basic strategies for promoting resident involvement in appropriate domestic talks, 2) older providers are given updated training with this same focus, and perhaps incentives for involving persons with more severe impairments in domestic tasks, 3) technical assistance and inservice training are provided specifically on the performance of domestic tasks, including modifications of tasks to accommodate individual members of the household, and 4) expectations are clearly established that people in community residential environments should be included in maintaining those environments.

Personal Autonomy

Personal autonomy includes areas such as independence, self-expression, and choice-making. The discovery and descriptions of the absence of such culturally valued opportunities in institutional settings have been among the more potent incentives to develop community based settings (Braginsky & Braginsky, 1975; Goffman, 1961). Again, it has been consistently found that community facilities are on the average considerably superior to institutions in granting and promoting personal autonomy (King, Raynes, & Tizard, 1971; Rotegard, Hill, & Bruininks, 1983; Silverstein, McLain, Hubell, & Brownlee, 1977). In general this study found that most residents in community facilities were provided opportunities for choice and self-expression, but again there was evidence that many people were provided fewer of these opportunities than they probably ought to have been provided. For example, while a majority of residents (58%) were reported to be able to select the clothes they wore each day, 10% of careproviders said they made the decision exclusively by themselves. A total of 15% of careproviders said that they alone determined the decoration of the sampled resident's room, although 40% reported that room decoration was entirely at the discretion of the resident. A substantial majority of residents were in settings that permitted individualization of nighttime hours, but less than one-third of residents in facilities where overnight staff slept were permitted to stay up after the staff member went to bed. A minority of adult residents who shared bedrooms were given the opportunity to select their roommates, much less to decide if they wanted roommates. Despite the limitations on autonomy

and important choice-making in the lives of people in residential settings no staff members saw a substantial need for training in means to enhance the autonomy, self-determination and expression of personal preference among residents.

Clearly personal autonomy and self-expression is valued in our society. Among persons in residential settings it tends to be associated with community living. Still it varies substantially according to resident characteristics (e.g., lowest among persons with more severe impairments) as well as provider characteristics (e.g., lowest among foster care providers). It is clearly important that better effort be made to orient careproviders to the needs, benefits and rights of persons with developmental disabilities to enjoy opportunities for the maximum appropriate amounts of autonomy and choice in their lives. It is also important to view the careproviders' role in personal autonomy as more than merely providing opportunity. For many current residents of community facilities and many more of the future residents who will more often have severe cognitive impairments and years of acquired dependence, it will be necessary to view independence, choice-making and self-expression as a "skill." This will involve: 1) greater amounts of direct teaching of residents in choice-making and expression of preference, 2) systematic integration of choice making and expression throughout the individual's daily life, and 3) provision of more frequent and more basic opportunities for all people with developmental disabilities to express choices. The first two of these requirements appear relatively infrequently represented in the programs for people in community residential facilities. The third, while usually present in at least certain aspects of the lives of community residents and certainly much more common in community settings than in institutions, is also by no means universal. Greater effort must be made to see the promotion of personal autonomy, choice and self-expression as important goals in residential programs.

An important aspect of increased personal autonomy and self-expression is the opportunity to live as independently as possible in the community. The findings in Chapter 4 indicated significant numbers of persons in this study enjoyed excellent health and high levels of adaptive behaviors in areas of personal care and community living skills. The adaptive behavior characteristics of the sample

suggest that many persons in these residential programs may be capable of far greater degrees of independent living. This is obviously an important aspect of promoting greater personal autonomy for persons with mental retardation, but it also represents an important matter for public policy. It is estimated that tens of thousands of persons with mental retardation living at home are on waiting lists for residential and other community services (Davis, 1987). Without promoting greater independence among large numbers of persons now in residential programs, it seems unlikely that states will even begin to be able to address the growing demand for services with the resources likely to be available.

To summarize briefly the findings of this study, it was found that a substantial majority of community facility residents have achieved at least modest levels of integration into some important aspects of community living and integration. The finding that the average group home resident has about as much domestic responsibility as the average member of the general population, and that the average foster or group home resident has greater recreation/leisure integration than the average member of the general population exemplify the most positive of findings on integration.

However, in all, this study indicated, perhaps not surprisingly, that community facility residents were generally not as well integrated into the life of the community as were members of the general population. The absence of differences between the two groups in age, gender, community type and proximity to public transportation, and the closer proximity of community facility residents to stores (and presumably therefore other leisure settings), support attributing these differences to the differences in living arrangements, to differences in abilities, to differences in expectations and social attitudes, and quite likely interactions between these and other factors.

The differences between facility residents and the general population in their integration into the community was particularly evident in the areas of vocational/educational integration and in social integration. Few members of the study participated in normal work environments or regular schools. These might be considered among the more intellectually and socially demanding areas of community life, as opposed for example to community resource use or domestic participation, which are essentially defined by activities rather than interaction. But it is also the case that the vocational-educational and

social areas are the ones in which integration is most dependent on the attitudes and acceptance of others in the society. But the problem with such generalizations is that, with the exception of vocational/educational integration which was, perhaps, largely out of direct control of residential providers, many community residents exhibited degrees of adaptive behavior skills and community integration that were at or above the national average. That is, there were in the sample, people with mental retardation who know and visit their neighbors, who use the resources of the community, who decorate their own rooms and pick their own roommates, and so forth, although this level of "community integration" was far from the typical experience.

The analyses of data gathered in this study suggest that if integration and independence into the community are goals of community living increased efforts to promote them are needed. It was apparent from the study findings that greater progress must be made in the development of regular employment, supported living and social options. Some of these efforts might be tailored to specific areas for specific types of facilities (e.g., increasing domestic activities among foster home residents), but in general the challenge is primarily one of assuring that the positive levels of integration and independence reported for many numbers of the sample become more commonly available to all community facility residents. Doing so clearly means improved training, improved monitoring, promoting more accommodative attitudes in the larger community, and learning more about the means to community integration for people with the most severe impairments. There are already many excellent examples of successful, integrated programs in employment, education and social and leisure activities and other areas of community living to guide these efforts (e.g., Horner, Meyer, & Fredericks, 1986; Powers, 1988; Taylor, Biklen, & Knoll, 1987). But even fully accepting the current limitations of community facilities in assuring full integration, the most predictable way to promote social involvement, personal development, community participation, and independence for people with developmental disabilities in residential settings remains providing them the opportunity to live in small community-based settings.

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